HEALTH INSURANCE AND THE UNINSURED

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

APRIL 6, 1989

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HEALTH INSURANCE AND THE UNINSURED

THURSDAY, APRIL 6, 1989

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:13 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 22, 1989

PRESS RELEASE #8
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
HEALTH INSURANCE AND THE UNINSURED

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on health insurance and the uninsured. The hearing will be held on Thursday, April 6, 1989, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing Chairman Stark said, "I continue to be amazed that we let hard-working Americans fall between the cracks of our health insurance system. We must continue our effort to find a workable solution to the problem these people face anytime a family member gets sick."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

In 1987 there were an estimated 35-million Americans without health insurance and another seven-to ten-million Americans with partial coverage for a portion of the year. The number of uninsured Americans is growing. Fifteen percent of the non-farm population were not covered in 1980, while about 18 percent were not covered in 1987.

A recent survey by the Robert Wood Johnson Foundation confirmed a decline in access to care since the Foundation's 1982 study. This decline in access was particularly harsh for the poor, minorities, and for the uninsured. For example, 13.5-million Americans reported not receiving medical care for financial reasons. The study found an eight percent decline in physician visits by the poor, in fair or poor health, between 1982 and 1986.

The hearing will focus on alternative proposals to provide health insurance to the 35-million Americans without health coverage.

A number of proposals have been made recently regarding alternatives for universal health insurance coverage. Among these are a proposal from the National Leadership Commission on Health Care, a "Consumer-Choice Health Plan" presented by Professors Alan Enthoven and Richard Kronick, and a proposal by the Physicians for a National Health Program. The state of Massachusetts has also recently enacted legislation to provide comprehensive coverage.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, April 21, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

*****

Chairman STARK. The Subcommittee on Health will begin a hearing this morning on health insurance and uninsured Americans. The access to health care should be considered a basic right for every American. Tragically, our society has not yet reached that goal; and it appears that we are slipping further away from it every year.

I am particularly concerned, because in my home county we have now institutionalized the problem. Alameda County in California has hired a triage expert; and what we are doing is paying this guy $50,000 a year to pull the plug on those least deserving to live. Our county hospitals run out of money; and I am serious. We are prioritizing those poor citizens in our county for whom specialized treatment is not available because of lack of dollars. And there is one other area in the country that is also doing this.

That is obscene, in the opinion of the chairman. And one would hope that, in a country where basically people all receive health care, medical attention—arguably, many too little and too late—society is paying that cost. Because we lack immediate care, or health insurance, if you will, bronchitis becomes pneumonia; and a tummy ache turns into a burst appendix; and early diagnosed diabetes becomes a trauma shock problem; all of which are five, six, seven times more expensive to treat.

I am not sure that we could ever prove, but I suspect we could, that early treatment—dollars spent on early treatment—would come back fivefold and sixfold and tenfold over in savings in future years. I wish we could turn those thoughts into empirical proof for our various budget committees so that we could be scored for it; but unfortunately, we cannot.

There are an estimated 35 million Americans without health insurance; many of them employed; many of them children. I think this committee in particular knows the benefits and the cost of those benefits well. We deal with them day in and day out; and our staffs are rather expert in determining what the costs of the benefits that we wish to provide are.

When it comes to how we will pay for those costs, however, there is yet to be a consensus. It is my hope that the witnesses today will not deal with whose fault it is. I do not care whether the Government has not provided enough through one system or another, or whether the private health insurers have not provided enough, or whether doctors and hospitals charge too much, or we pay them too little, and we are forcing them out of business. The question is, prospectively, what will we do.

It seems to me that the biggest part of that problem is not what to do, but how to pay for what we all know we must do. I am looking forward to the suggestions of our witnesses today. I am going to ask all of them, as we have in the past, to summarize or expand on their prepared testimony; all of which we have received in advance and will, without objection, appear in the record in its entirety.

[Mr. Stark's opening statement follows:]

OPENING STATEMENT
HONORABLE PETE STARK
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

HEARING ON HEALTH INSURANCE AND THE UNINSURED
April 6, 1989

Today the Subcommittee on Health continues its series of hearings on health insurance and the uninsured.

Access to health care should be considered a basic right of every American. Unfortunately, our society has not yet reached that goal, and it appears that we are slipping further away from it every year.

In 1987, an estimated 35 million Americans were without health insurance. From all signs the number of uninsured Americans is growing, with about fifteen percent of the population uninsured in 1980, while over eighteen percent were uninsured in 1987.

The most startling statistic associated with the uninsured is that the majority are employed. Nineteen million people or fifty-five percent of the uninsured were employees and almost seventy percent of this population live in families of full-time, full-year workers. For most of these families, the family head experienced no unemployment.

For all of these families without adequate health insurance coverage, any encounter with the health care delivery system, no matter how minor or seemingly routine, presents serious financial consequences. The unsurprising result is that these families do not seek appropriate health care when they need it.

Today we will hear the results of significant research conducted in the District of Columbia comparing hospital admissions by neighborhood. Again, perhaps not surprisingly, this research clearly shows that people from poor neighborhoods are admitted to the hospital far more frequently for preventible causes, illnesses for which the more affluent seek and receive early care outside of the hospital.

This research certainly implies that our short-sightedness as a society in not providing health insurance to all not only prevents the uninsured from receiving the care they need, but it ends up costing us more, as the uninsured seek costly hospital care.

Moreover, the increase in bad debt and charity care is putting a difficult burden on the backs of those hospitals which try to step in and shoulder the load. In 1986, hospitals provided $8 billion in uncompensated care. This is a particularly difficult burden for public hospitals which have only about 21 percent of hospital beds, but provide 55 percent of all charity care.

We are also fortunate today to hear from a number of witnesses with specific proposals to deal with the problem of the uninsured. In particular, I would like to welcome our former colleague, the Honorable Paul Rogers, who is co-chairman of the National Leadership Commission on Health Care. I look forward to hearing from him and our other witnesses on their proposals to resolve this important question.

The goal of comprehensive health benefits for all is one that has eluded us since the Congress first took up the question of universal health insurance in 1918. I hope that the rising level of interest in responding to this problem will mean that we can finally make meaningful progress towards solving it.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Mr. Chairman, I am delighted that you have set time aside for a hearing on this very important subject. I look forward, as I know all the members of the subcommittee do, to whatever testimony is presented to us today.

I want to say, however, from my own point of view, that my experience, at least prior to this morning, is that we get a lot more ideas on what the gaps are than how to fill them from a financial point of view. And I want to say, and I mean this in the most constructive spirit, Mr. Chairman, to all of our witnesses in advance, that unless you can spell out some reasonably practical way to raise the money, all we are doing is raising false hopes that we can fill these obvious gaps that exist. We know the gaps exist. And I think the reason that we are here today, and the reason we have not done more, is, at least as I see it, the public would love to have more services from the Federal Government, but wants somebody else to pay for it.

Maybe I say that because we are in the midst of the budget cycle; and I am circulating between meetings of the Budget Committee and this committee, and back again. But I really believe that is where it is at; and I hope that the financing question is not overlooked by our witnesses.

Thank you.

Chairman STARK. Do any of the other members have a statement before we turn to our first witnesses?

[No response.]

Chairman STARK. If not, it is my distinct honor and pleasure to call our first witness, a member of our committee, the Honorable Don Pease from the State of Ohio, whose interest in this area has been intense; and whose work we all look forward to. He has been very creative, very helpful, and he has a bill, H.R. 2696, that I believe we will hear more about in his testimony.

Welcome to the committee, Don, and please proceed in any manner you desire.

STATEMENT OF HON. DON J. PEASE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. PEASE. Well, thank you very much, Mr. Chairman and members of the subcommittee, for the opportunity to testify this morning.

As you suggested, Mr. Chairman, it is a scandal that 35, 37, 38 million people in this wealthy Nation with the finest health care system of any country in the world lacks the insurance that would make ordinary health care accessible to them.

Each of us here today emphasizes a different approach to this problem; but I think we all share a concern for those who need health care but cannot get it because they lack the ability to pay. This is a problem that we on Capitol Hill are hearing about more and more from our districts.

I would like to share with you this morning a brief excerpt from a letter written by one of my constituents. I received it just this week.

She writes,

I have recently been overwhelmed by medical bills. I do not have the hospitalization, nor can I afford to have it. I am one of those people who fall between the cracks, not making enough money to afford the protection of hospitalization, nor poor enough to get public assistance. I now have no choice but to hope that the Government will help with the medical bills. What angers me most is that I am put in this situation. In this rich, affluent country, we give billions of dollars to other countries, plus that much and more to Star Wars and other Defense and benefit programs. Why can't we get a Government hospitalization plan that we can afford, something that is realistic?

Well, Mr. Chairman, I believe that my bill, the Universal Health Insurance Act, is such a plan. It would create affordable, comprehensive health coverage that citizens could buy into if they so desired. Building on the Nation's existing system of private and nonprofit health insurance, my plan would be noncoercive and would require reasonable payment from individuals receiving the insurance coverage.

Under the plan, State insurance pools would be created based on competitive bidding among insurance carriers. Citizens could then purchase the insurance for a sliding scale of 6 to 8 percent of their income and assets. This income and asset level would be determined by an independent agency, similar to the way need levels are determined for student loans.

A portion of the cost of the insurance not covered by the sliding scale payment would be picked up by the Federal Government. What would the cost be? Not cheap. But no program could be that aims to fill such a major void in the Nation's health care system. Some of the cost of the plan, under my bill, would be offset by doubling the tax on cigarettes. A tax increase on cigarettes was supported by 61 percent of the American people in a recent Gallup poll.

The plan would be completely voluntary; and although it would not be tied to employment, employers could offer insurance under my plan as an option to their employees who choose to participate. Employers would be encouraged to offer health insurance through the imposition of a new health plan employment tax, which would be waived for employers offering adequate insurance plans to their employees.

A national health system would solve the problems of the uninsured. That is to say, something along the lines of the Kennedy proposal from a decade ago. But the political barriers to passage of such a plan would be enormous. In addition, the institution of a national health system would be very expensive at a time when reducing Federal deficits is already the Nation's chief vexation.

Employer-mandated insurance, another option, would threaten the ability of many small firms to compete; and it would not provide health insurance for a large proportion of the uninsured who are self-employed or unemployed, but not poor enough to qualify for Medicaid or old enough to qualify for Medicare.

In my view, my plan is the only one that I am aware of for which the cost is not excessive, the philosophical and political hazards are reasonable, and the mechanics of the proposed system appear practical. I urge you to look at my plan seriously and soon.

The problem of the uninsured is not diminishing. It is getting worse; and we must take urgent steps to remedy it. The American people deserve no less.

Thank you very much, Mr. Chairman.

[The statement of Mr. Pease follows:]

STATEMENT OF HON. DON J. PEASE
HOUSE WAYS AND MEANS, SUBCOMMITTEE ON HEALTH
THURSDAY, APRIL 6, 1989
10:00 A.M. 1100 LONGWORTH

I would like to thank the Subcommittee and especially Chairman Stark for the opportunity to head up the distinguished list of individuals testifying today. It is a scandal that in this wealthy nation with the finest medical system in the world, 37 million people lack the insurance that would make ordinary health care accessible to them. Although each of us here today emphasizes a different approach to this problem, I think we all share a concern for those who need health care but cannot get it because they lack the ability to pay.

This is a problem that we on Capitol Hill are hearing about more and more from our home districts. I would like to share with you excerpts from a letter written by one of my constituents:

"I have recently been overwhelmed by medical bills. I do not have hospitalization nor can I afford to have it. . . I am one of those people who fall between the cracks, not making enough money to afford the protection of hospitalization nor poor enough to get public assistance. I now have no choice but to . . . hope that the government will help with the medical bills. . . What angers me most is that I am put into this situation. In this rich, affluent country we give billions of dollars to other countries plus that much and more to Star Wars and other defense and benefit programs. . . why can't we get a government hospitalization plan that we can afford? Something that is realistic?"

My bill, the Universal Health Insurance Act, is such a plan. It would create affordable, comprehensive health coverage that citizens could buy into if they so desired. Building on the nation's existing system of private and non-profit health insurance, my plan would be non-coercive and would require reasonable payment from individuals receiving the insurance coverage.

Under my plan, state insurance pools would be created, based on competitive bidding among insurance carriers. Citizens could then purchase the insurance for a sliding scale of 6-8% of their income and assets. This income and asset level would be determined by an independent agency, similar to the way need levels are determined for student loans. The portion of the cost of the insurance not covered by the sliding scale payment would be picked up by the federal government.

What would the cost to the federal government be? Not cheap -- but no program could be that aims to fill such a major void in the nation's healthcare system. Also, some of the cost of the plan could be offset by doubling the tax on cigarettes. A tax increase like this was supported by 61% of the American people in a recent Gallup poll.

This plan would be completely voluntary, and, although it would not be tied to employment, employers could offer insurance under my plan as an option to their employees who choose to participate. Employers would be encouraged to offer health insurance through the imposition of a new health plan employment tax, which would be waived for employers offering adequate insurance plans to their employees.

A national health system would solve the problems of the uninsured, but the political barriers to passage of such a plan would be enormous. Also, the institution of a national health system would be very expensive, at a time when reducing federal deficits is already the nation's chief vexation.

Employer-mandated insurance would threaten the ability of many small firms to compete, and it would not provide health insurance for the large proportion of the uninsured who are self-employed or unemployed but not poor enough to qualify for Medicaid or old enough to qualify for Medicare.

My plan is the only one for which the cost is not excessive, the philosophical and political hazards are reasonable, and the mechanics of the proposed system appear practical. I urge you to look at my plan seriously -- and soon. The problem of the uninsured is not diminishing. It is getting worse, and we must take urgent steps to remedy it. The American people deserve no less.

Chairman STARK. Thank you, Don. Your plan seems to concentrate on low income.

Mr. PEASE. Low income?

Chairman STARK. Lower income.

Mr. PEASE. Yes.

Chairman STARK. Do you see this fitting into other plans; or do you think it should be comprehensive and cover all income classes? I am not sure I understand.

Mr. PEASE. Mr. Chairman, the basis of my plan is that it would be available to anybody; but that under the premium structure, those with incomes, say about $30,000, would not have any incentive to participate in the plan.

Let us say an insurance pool would set up a system of health insurance, a health insurance plan for individuals, that takes care of hospitalization and basic doctor bills and so on. And let us say that plan is worth $2,500 or $2,000, we would make that plan available to anybody who wanted to have it, no exclusions, anybody, for 6 percent to 8 percent of the person's income.

For low-income people, our premium would be, say at the minimum wage, about $420 a year. For those earning $20,000 a year, the premium for the identical policy would be about $1,500. For those making $30,000 a year, the premium would be in excess of $2,500; they would be just as well off going off and buying their own plan.

So there would be an automatic tendency to graduate people, but no cliff over which people would go and be no longer eligible.

Chairman STARK. Based on, say, the alacrity with which certain States are buying into Medicaid for their catastrophic beneficiaries, and with which they provide Medicaid to their own residents, one can predict certain States which are not going to establish pools and are not going to be troubled with it. What do you do with them?

Mr. PEASE. We do not give States the option. The pools would be set up using the States or parts of States as the area to be covered. But the pools would be established by the Federal Government, not by the States.

Chairman STARK. And the Federal Government would operate the pools?

Mr. PEASE. The Federal Government would put out a proposal for bids to Blue Cross, Aetna, any carrier.

Chairman STARK. What if no one comes to the party? What if no one bids?

Mr. PEASE. Well, I think that is unlikely, but possible. We would say to the companies, "How much would you charge to provide the basic policy which we outlined for you?"

Chairman STARK. Suppose you get one bid for $10,000 per year per person; then what do you do?

Mr. PEASE. Well, I think that would pose a cost problem. My assumption is that competition will come into play.

Chairman STARK. With an industry that is exempt from antitrust? Let me try this, then. What would be wrong, and why would it not be simpler, just to make Medicare benefits available to these people at no cost to the Federal Government?

Mr. PEASE. At no cost to the Federal Government?

Chairman STARK. Or let them pay the cost to us.

Mr. PEASE. Well, I think in that case, the cost of the policy would be prohibitively high for very low income people.

Chairman STARK. No less than what any private insurance company could do it for?

Mr. PEASE. Less than what?

Chairman STARK. Less than any private insurance company could do it for.

Mr. PEASE. Oh, that is true. But let us say, under my plan, the policy for a person working full time at the minimum wage would be $420 a year. I presume, if we were to allow people to buy into Medicare, it would be substantially higher than $420.

Chairman STARK. I am sure it would be. What I am suggesting, though, is that with the net cost to the people you are concerned about, somebody has got to make up the difference between the $420 and the cost. Why not take the lowest cost plan in town, and make that available?

Mr. PEASE. I would have no objection to having Medicare be one of the competitors, if you will.

Chairman STARK. With no overhead and no extra cost, it is pretty hard to compete.

Mr. PEASE. Well, Mr. Chairman, as you know, we have got some problems with Medicare and Medicaid in terms of acceptability by the medical fraternity.

Chairman STARK. But we have yet to have any problem with the acceptability of money from that same fraternity. So once it is turned into cash, they quickly forget from whence it comes.

Mr. PEASE. Let us just say that.

Chairman STARK. In other words, you would not have any objection to suggesting that, as an insurer of last resort, we could make available Medicare to anyone who wants to buy it?

Mr. PEASE. I would not have any objection to that at all. But I would like to retain the sliding scale, so that persons with very low income are subsidized.

Chairman STARK. I am suggesting that same thing.

Mr. Gradison.

Mr. GRADISON. No questions. Thank you, Mr. Pease.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you. I appreciate your testimony. And I think it holds enormous potential. First of all, I think that letting people buy into the public programs, considering the enormous overhead of public programs, is an approach that carries a great deal of difficulty with it.

I think your comment that competitive bidding would matter is one that I agree with. But I am particularly concerned with one aspect of your proposal that you do not mention in your testimony. In order to make this work, we have to define the plan for the bidders. And in my experience, when Government gets involved in the definition of what is sort of a minimal family support benefit, we have a hard time not mushrooming that into Rolls Royce coverage.

My State, for example, has many mandates about what plans must cover. If you accept all those mandates, you cannot have a sort of minimal cost, maximum practical benefit plan. I think that a minimal cost and practical plan is out there.

I have a sister who is a single parent who, for a $500 deductible and a $500 premium got very good coverage under which, frankly, she collected an enormous amount as a result of prolonged hospitalization of her child. So it is out there. Reasonable cost coverage can be bought in the private sector; but it cannot be bought in those States that have layered on a lot of mandates.

So to make yours work, we would have to be capable of defining basic coverage; and we would also have to be willing to override State mandates for this special market. We would have to mandate—I would hope that we would also mandate—that every major health care provider in the private sector, every major insurance provider, have a plan that meets those specifications so that we force competition. But would you be willing to override States on this issue of definition?

Mr. PEASE. Mrs. Johnson, it would not be a matter of overriding the States. Under my bill, the States have no role whatsoever. We are looking at the States really as geographic areas, and saying "the Federal Government," not "the States," means, "The State of Connecticut is a bidding pool. Upstate New York is one. New York City is another."

And then say to the private and nonprofit insurance companies, "How much would you charge to provide a policy with the following features for these areas?" And the outlines of the features would be established by this subcommittee in legislation, and the implementing rules would be drafted by HHS. The States would have no role whatsoever under my plan.

Mrs. JOHNSON. I think this is an approach that deserves a great deal of consideration. Partly, it could be a means by which, eventually, we could eliminate Medicaid as we know it. Because Medicaid is, in fact, failing our poor people. It does not provide them access. In many instances, it provides them with the same access as the uninsured, which is zero.

So I am very interested in working with you on this, Don, and I appreciate the thoughtfulness of your proposal.

Mr. PEASE. Thank you. I appreciate your saying that.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. I would like to thank my colleague also for his comments and his approach. I think we all agree on the fact that we have a very serious problem. And how to address it has become most troublesome to us. Too many people in my view are looking toward some massive global Federal fix. You are one of the thinkers on this committee; and I think this is reflected in the very thoughtful suggestions that you have made.

One thing that I would like to say is that I think the revenue source that you have selected is right on target; probably more people are afflicted with disease because of the use of cigarettes than anything else they do. The one thing I think I would suggest in addition—and I hope my friend from Minnesota won't take offense—is that for those on this committee and for every other American, we ought to also tax cigars to make them prohibitively expensive so that we do not have to smell the damn things anymore.

Mr. PEASE. Thank you, Mr. Chandler. If I might make one comment, Mr. Chairman—and not about the taxation of cigars—I put a

lot of thought in this proposal; and I hope it is not the kiss of death to say so, but I really think that it ought to appeal to conservatives and Republicans, perhaps in the sense that it makes use of the private sector. It is not coercive. It makes insurance available to people. It does not force them to have it; and has a minimum of Federal Government intervention.

Mr. CHANDLER. That is not a blasphemous statement, even from a Democrat. More. More.

Mr. PEASE. Well, as I say, there is always a little danger of that.

Chairman STARK. Thank you very much, Don. I appreciate you taking the effort and time to work on this problem with us; and look forward to working with you as we try and solve it ourselves.

Our next witness is a distinguished Democrat, head of the Democratic Study Group, the Honorable Martin Sabo, a member of the Democratic Farmer Labor Party of the great State of Minnesota, representing the Fifth District, which he has represented over 10 years with expertise and high popularity. He is a member of the Appropriations Committee; serves on the subcommittees of Transportation, District of Columbia and Defense. He is a man of great perspicuity and, like me, dreads the days of $10 cigars or $10 glasses of wine; but realizes that progress must be paid for by someone. He is here to talk to us today about, I presume, issues of health that are beyond just the DSG's task force, but a bill that he is very interested in.

And we would like to hear from you, Marty. Proceed in any way you are comfortable.

STATEMENT OF HON. MARTIN OLAV SABO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. SABO. Well, thank you, Mr. Chairman; and frankly I do not mind that cost for wine, but I would for cigars. [Laughter.]

I thank the chairman and members of the subcommittee for the opportunity to appear. I am appearing as an individual, not as a representative of DSG. My concern reflects an interest I have had in this issue for many years, preceding my service in the Congress when we developed a fairly comprehensive catastrophic health insurance plan for the residents of our State, created a State pool, and began to address some of these problems.

You have heard many descriptions of the problem. Let me simply reverse it a little bit; 80 to 85 percent of the population of this country have fairly good health care coverage, whether it be through public sector or through the private sector. In my judgment, what we should be looking at is how we fill the gaps that exist for those people who do not have access to health care and cannot afford it. We should be filling the holes, not overthrowing the entire system. And in my judgment, there are really two problems. They are related, but not identical.

There is one question of access; and there is another question of cost. While they are related, they are not the same. And I would hope that as we deal with this problem, if we can begin to make a dent in the access problem without solving the total cost problem, that we would still take whatever steps we can to move forward.

I would suggest, in dealing with access, that private group health insurance works fairly well. And we should try to a maximum extent to expand the ability of the private sector to deal with the question of access to health care.

I would suggest that we require all businesses with 10 or more employees to be required to offer group health insurance to their employees. My bill, however, does not take the next step.

Chairman STARK. Excuse me, could I interrupt? You mean, just offer? The employees must pay for it, but it is offered?

Mr. SABO. We are silent on the issue of who pays. I have no philosophical problem with us mandating that employers pay part of the premiums. However, my judgment is that that is not likely to pass. On the other hand, it has also been my observation that group insurance is fundamentally much better than an individual policy. Obviously, the question of whether it is 10 or more, or some other number of employees for the requirement, is subject to legislation.

My own judgment would be that the nature of the Tax Code that we have developed would gradually change, naturally, who pays that premium. There are obvious tax advantages to having your employer paying part of your health insurance premium, because it is nontaxable income. I think quickly it would evolve into a system where the employer is paying a portion of that premium. That would be the natural inclination of an employer and desires some employees, because of the Tax Code.

I have also discovered that many of the people that are vehemently opposed to proposals for mandating access plus mandating that employers contribute to premiums do not have quite the same opposition to saying simply that we should mandate access. I also have some fear that if we do mandate a certain premium split that that would become the norm when, in fact, for many employees around the country, they have over the years negotiated a better premium split than what we would be likely to mandate.

I would go a step beyond that in providing access for those who do not work for an employer who employs 10 people and I would create a State pool. I would do the opposite of Mr. Pease. I would make it a State pool, so that the rest of the people could have access through a State pool for those who are self-employed, those working for smaller employers. A smaller employer might be willing to use that as, in fact, a group insurance plan for his employees.

The State pools, I think, should be State run. They should have involvement of insurers on a board. To make it work, I think you need to have a limit on premiums. In our proposal, we limit the premiums on the State pool to 105 percent of the cost of the State group insurance premiums. So it is somewhat more than a typical large group plan; but should be less than most individual policies.

You would have to have some feature where, if in fact the cost exceeded that, a State could subsidize extra cost, depending upon what the risk selection of that pool would be. In our State, we have a State pool currently; but that is entirely for folks with health problems. So clearly, the premiums are substantially higher than the norm. Here, you would have broader access to it; not simply limit it to people with health problems. And in fact, I think you

would find that many of the people having access through the pool would be younger and, in fact, would not be the most high-risk people.

So I would suggest two basic approaches in dealing with access. One, requiring employers with 10 or more employees to offer group insurance. Second, having a State pool in which people can buy in who don't fit the other category. So how do you deal with the cost question? That clearly involves, I suppose in the end, where we find revenues.

However, I would suggest that we make it a State-Federal program. The bill I have introduced would say that we have a fixed expenditure; that we provide $10 per capita to every State in the country to at least be matched by the States for the States to develop a sliding fee scale to help people buy into the program. We would depend on the States to design that program. It could vary from State to State. The maximum Federal cost would be approximately $2.5 billion.

I do not claim that would cover the entire cost of the program, or cover the entire problem that we face; but that approach, in my judgment, would be one that would have a controllable Federal cost. It would clearly make a major dent in the problem of lower income people buying into the program.

I would suggest, as you look for revenues, and in my judgment, that is a problem we face throughout the Government; that if at any point you decide that the Medicare tax should be levied on all incomes, I would suggest that any part of that that is more than needed to pay for Medicare, a prime candidate for any of those excess revenues should be a program for dealing with access to health care for people who are in the work force.

I would also suggest, if we cannot do any of this, that you should take a look at the potential of a catastrophic health plan. Our experience in our State was that we had a catastrophic health plan with fairly high deductibles that worked very well. And our bill suggests that we have one which would have deductibles of $2,500, or 30 percent of household income up to $25,000; 40 percent of income between $25,000 and $40,000; 50 percent of income over $40,000 would be an annual deductible. It is not one that covers day-to-day costs; but it is one that would assure everyone that they are not totally annihilated by any type of medical expense.

In my judgment, that type of program could be instituted on a national basis for fairly modest costs. But if we want to deal with the problem, making sure that nobody is absolutely wiped out, we could do it and do it at a fairly reasonable cost, based on my experience.

If the committee has any questions, I would be glad to respond.

[The statement of Mr. Sabo follows:]

Testimony by
The Honorable Martin Olav Sabo

HEARING ON HEALTH INSURANCE AND THE UNINSURED

Subcommittee on Health
Committee on Ways and Means

April 6, 1989

Mr. Chairman and Members of the Subcommittee. I appreciate the opportunity to appear before you today as you examine the problems faced by the 37 million Americans who do not have health insurance and explore various solutions.

It is unconscionable that the United States allows one in six of its citizens to go without even the most basic protection. This is a national tragedy that we can no longer ignore.

I am convinced that we must make it a top national priority to repair the deficiencies in a system that lets so many people slip through the cracks. The problem is simply too big, too costly, too tragic for millions, and too harmful to our fellow citizens. In a country as wealthy as ours, we should guarantee that all Americans have access to comprehensive and affordable health insurance.

This morning I would like to outline my thoughts on the problem and the approach I think we should take to address it. I would like to tell you about legislation I have introduced -- H.R. 872, The Comprehensive Health Care Improvement Act of 1989. This bill is an updated version of legislation I have introduced each session for the last decade.

BUILDING ON THE EXISTING SYSTEM

The current system of private health insurance and such public programs as Medicare and Medicaid works fairly well for most Americans. We don't need to throw that system out or make drastic changes in it. We don't need to create large, new bureaucracies. Instead, by patching the holes in the existing system and building on it, we can ensure that all Americans have access to quality, affordable care.

This approach -- building on the current system -- makes the most sense to me. It would be an effective solution and the most politically feasible and acceptable one.

Of course, in any discussion of health insurance and the uninsured, we must consider two problems -- access and cost. The unemployed and workers who's jobs do not include health benefits too often do not have access to insurance plans at group rates.

Individual policies frequently provide only limited coverage and they can be very costly. Some people cannot obtain policies at any price, because of a medical condition. And, in cases where employers require employee contributions, lower-income workers may not be able to afford to pay the premiums for themselves and their families.

My bill would fill in the gaps in the current system and address the access and cost issues. It does this in a comprehensive, simple, straight-forward, and relatively low-cost way. Briefly, here's how it would work:

PROVIDING ACCESS

To provide access for most of the uninsured, my bill would require businesses with ten or more employees to offer coverage to their workers. The plans would have to meet specified, minimal standards and cover the employees' dependents. Firms would not be required to pay the premiums, but at least most people would gain access to good coverage at group rates.

To provide access for the rest of the uninsured -- those who work for smaller firms, the self-employed, and the unemployed -- states would be required to establish pools of all health-insurance companies. In other words, a new group is created of all people not eligible for regular group plans and others who wish to buy from the pool. Anyone, including businesses, could buy insurance from the pools.

Rural Americans -- who are more likely to lack insurance than urban Americans -- would be helped by the pools. One-third of all agricultural workers and their families are uninsured.

I place a cap on the premium that could be charged for a pool policy to ensure that it remains affordable. States would administer the pools and determine the best way to cover pool losses. Options they might consider are using general revenues, levying some kind of a tax, and assessing insurers and self-insurers directly.

Under this system all Americans would have access to group insurance. Many of the uninsured could pay for at least part of their own insurance if they could get it at group rates. Nearly one in five of the uninsured live in families with incomes of more than $30,000.

HELPING WITH COST

But many individuals and families would still be left out. They may still have a tough time paying for coverage. To help these people my proposal would set up an optional state-federal low-income assistance program.

Each state could design a program that best meets its needs, experiment with alternative subsidizing methods, and decide how to pay for it. States could experiment with such alternatives as sliding fee schedules, subsidizing premiums completely, and cost-sharing.

The Federal Government would pay half the program's cost up to a maximum of $10 times a State's population. If every State participated fully, the maximum Federal liability would be $2.5 billion.

ACCESS BEFORE COST

As you can see, my bill's primary focus is on the access problem. That is because I believe that providing access should be our first priority.

One of the main differences between my proposal and others is that it does not require employers to pay part of the premiums. I have no fundamental problem with mandating that employers contribute. It is an approach I could support. But I would hate for a debate over who pays -- or the relative mix of payment -- to keep us from taking any action at all. Providing access to affordable coverage should be our top priority.

Despite my emphasis on the access question, my bill also addresses the cost issue. It does so by providing access to cheaper, group coverage and by creating the low-income assistance program.

PROTECTION FROM CATASTROPHIC ILLNESSES

Besides the millions of Americans who lack health insurance of any kind, millions more do not have adequate protection from catastrophic health-care costs. Last year we adopted legislation to help senior citizens. But we should protect young and old alike from the loss of their homes, businesses, or the bulk of their assets because of an extremely expensive illness. Financial ruin is just as serious -- if not more so -- for a young family.

We should ensure that no one is left destitute from a catastrophic illness. My bill would also create an optional state-federal catastrophic health insurance program. This part of my bill could be adopted on its own, as a free-standing program, or as part of this comprehensive package.

The program would help individuals after they exhaust their existing medical coverage. The program would cover 90 percent of all costs that exceed certain income thresholds.

This program would not be a substitute for conventional catastrophic insurance. The income thresholds are designed to be high enough to encourage people to obtain good coverage of their own and ensure that only truly catastrophic illnesses are covered. But they will still ensure that people are not financially ruined.

The Federal Government would pay three-fourths of the catastrophic program's cost up to $2.50 times a states population. If every state participates fully, the maximum Federal cost would be $620 million.

ADVANTAGES OF THE SABO PLAN

I believe that the concept I have outlined has several advantages:

One, it is truly comprehensive. It provides access to good and affordable coverage for everyone, not just the working uninsured or poor women and children.

Two, using state pools and having states run the programs gives us greater flexibility. It allows us to take advantage of existing expertise and bureaucracies. It encourages states to experiment with innovative approaches. And it lets states tailor programs to meet unique local needs and conditions.

Three, it would not be overly burdensome or disruptive for businesses. In fact, it would help small businesses provide a much-needed benefit for themselves and their employees and help them retain healthier workers.

Four, it offers catastrophic protection for everyone, not just the elderly.

ACTION NEEDED

The current debate is healthy and necessary, but we cannot afford to debate forever. It is inexcusable for a nation as rich as ours to continue to delay taking action. Since I first introduced similar legislation ten years ago, the number of uninsured has grown by more than eight million. The problem has gotten worse, not better.

My proposal is one possible solution to the problem. It fills the gaps in our health-care system in a fiscally responsible and realistic manner. I believe that a political consensus can be built around it and that is what we need -- something that can pass and be implemented.

Without a doubt, the problem is difficult and complex. But it is also solvable. Working together -- through a partnership of the federal government, states, and the private sector -- we can ensure that all Americans have access to affordable, quality care.

I appreciate the opportunity to present my views and outline my proposal and I welcome your questions.

# # #

Chairman STARK. In your bill for the employee in a less-than-10 size, you would make available insurance through a pool.

Mr. SABO. Right.

Chairman STARK. You cap the premium at the average, as I read it, charged by the average of five big companies' policies to individuals.

Mr. SABO. No, no.

Chairman STARK. To groups.

Mr. SABO. To State employees.

Chairman STARK. OK. So you cap——

Mr. SABO. So I cap it at 105 percent.

Chairman STARK. Of group insurance rates.

Mr. SABO. Right, for State employees.

Chairman STARK. Alright, then I misunderstood because the private rates would be considerably higher.

Mr. SABO. That's right. That's right, no I would agree with that.

Chairman STARK. Thank you. Mr. Gradison.

Mr. GRADISON. I have no questions.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you. Very thoughtful approach, I agree. I would just ask you the same question I asked Mr. Pease.

When capping the premiums at 105 percent of the premium for the major group plans in the State, would you also define the plan that should be available for purchase as being the equivalent of those plans?

Or would you have us define the plan that the State should provide? And if so, would you be willing then to require that States could now add additional mandates on our definition of the plan?

Mr. SABO. In my judgment I would leave that to discretion of the States, then you have obvious tradeoffs. The richer you make the plan, the more quickly you use up the Federal funds in a sliding fee scale. The leaner you make the plan, the further you can spread it.

Those are tradeoffs that might be decided in 50 different ways, and I have no great problem with having it decided in 50 different ways.

Mrs. JOHNSON. Thank you.

Mr. SABO. I'm not sure we have greater wisdom than each of the individual 50 States. Connecticut might well do it differently than Minnesota, and my experience has also been that there's significant diversity among the States.

I'll follow up on your suggestion earlier. I think there might be great merit to having some type of Federal law which puts standards on different types of plans. This should include a definition of a more minimum standard plan which could be bought at cheaper rates within our existing system.

There should be some definition of what those benefits are because I get disturbed at times by what I hear on television advertising about some plans which I suspect are real ripoffs.

As a matter of fact we tried to do this in Minnesota. We had, I think, plan A, plan B, plan C which were described. Plan A being a very comprehensive plan. Plan C being the plan with higher deductible, larger copayment, but it could still be described as a State certified plan.

Frankly, I have to say that as we tried to deal with this in the State one of our biggest problems was a whole barrier of Federal legislation that we ran into. Particularly—this is over 12 years ago so I tend to forget what all our problems were—but in federally regulated plans we couldn't regulate them and a whole series of other things.

Federal law kept us from doing lots of things we wanted to do on the State level. At that point in time, we wanted to mandate, for instance, a group conversion plan. Policies had to be equivalent to what the group plan was. We could do it as long as they didn't have any involvement with Federal law or ERISA as I recall it.

Once we ran into ERISA plans we couldn't do what we wanted and State law didn't apply. So Federal law was not helpful to us then. But this was back in the 1976-77 period.

Chairman STARK. I was going to suggest it's not better now. Somebody handed me a clipping from yesterday's Los Angeles Times. In Sacramento, Speaker Brown, introduced a plan which would have required employers with five employees to buy insurance. Then it talks catastrophic pools.

And it seems this plan was attacked from [laughter] every side and every direction. It has many of the features that your plan has. It happens to be mandatory, but I suspect that this is something you went through many years ago. The same kind of criticism in Minnesota.

Mr. SABO. Well frankly, we did not get into the mandating of individual employers. We found that, however, on our catastrophic plan that we passed, we basically did not have objections.

Chairman STARK. The risk pool?

Mr. SABO. No——

Chairman STARK. Castastrophic?

Mr. SABO. No, going beyond the risk pool. The risk pool we basically did not have problems with. The catastrophic plan we passed also did not have problems with.

But it ran into problems. Our experience frankly was that it cost half of what we estimated. And then the legislature enriched it substantially. Then they got into a budget crunch and instead of scaling it back again, they repealed the whole program.

So unfortunately it's gone, but it was in place for about a 2- to 4-year period or maybe 5 years. And frankly, it worked very well to make sure that nobody was totally wiped out by major medical expense in our State.

Mrs. JOHNSON. I do think it's a very interesting idea that capping the Federal reimbursements and allowing the States complete freedom might be a better approach, than trying to make the definitions of what minimal/maximal coverage are from the Federal level.

In doing that we would certainly have to provide some protection so that employers who wanted to use this would not be caught within some of the Federal webs that we are currently experiencing. Thanks.

Mr. SABO. My thanks to the committee.

Chairman STARK. Thank you very much Marty. Our next witnesses comprise a panel and they are representing the National Leadership Commission on Health Care. A former colleague, the

Honorable Paul Rogers, cochair of that committee, for many years ably represented the great State of Florida in the House. And I suspect was then and is now known as the leading expert on health legislation inside the beltway and beyond.

He's accompanied by Dr. Henry Simmons, the president of the commission, and Mr. John Sweeney, chairman of the health committee of the AFL–CIO. These gentlemen, the Chair happens to know, have worked, I think, for almost 2 years now—

Mr. ROGERS. About 2½.

Chairman STARK [continuing]. On a project which I think should generate great excitement among those who are interested in the medical and health delivery system in this country.

They represent an interesting coalition which has come to some, certainly not unanimous agreement on a proposal, but has a great deal more consensus than any group that I've been aware of in the recent past.

So it's with a great deal of anticipation that the Chair looks forward to hearing your testimony. Your complete prepared testimony will appear in the record in its entirety and you may each in the order that you appear on the witness sheet, enlighten us in any way you feel comfortable. Paul, you first.

STATEMENT OF PAUL G. ROGERS, COCHAIRMAN, NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE, ACCOMPANIED BY HENRY E. SIMMONS, M.D., PRESIDENT, AND JOHN SWEENEY, CHAIRMAN, HEALTH COMMITTEE, AND PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO

Mr. ROGERS. Thank you very much, Mr. Chairman, for your very kind remarks and your gracious introduction. As you said, I am accompanied by John Sweeney who is——

Chairman STARK. Paul, one thing, the 20th century has not found the electronics system in the Ways and Means Committee and it will only work if you attempt to swallow the microphone. You have to have a really——

Mr. ROGERS. I'm sorry I thought I was speaking loudly enough——

Chairman STARK. Pull it closer to you—you are, but in this room——

Mr. ROGERS. OK.

Chairman STARK. Pull it more closely to you.

Mr. ROGERS. Alright, thank you very much.

Chairman STARK. Thank you very much.

Mr. ROGERS. John Sweeney, who is president of the Service Employees International Union, AFL–CIO, and head of their health committee, and Henry Simmons, who is president of the commission and has a long background in health care. As you say Mr. Chairman—a group of citizens, private effort came together for 2½ years to study health care in the Nation.

We found as you have, of course, access, quality, and cost are the major problems, and the commission has tried to address those. This simply puts into the public debate some ideas, suggestions, and maybe different ways of doing things. But the main point, I think, maybe this committee now, and the Congress itself must

begin to look at and that is that piecemeal approaches will not work.

We've tried it with hospital care, where we said "Oh we're going to hold down the cost of hospital care and that would save the whole system." Well it saved some cost on inpatient care and what happened? Well, it is like pressing the balloon and the costs of outpatient care have gone up astronomically.

Now we're looking at doing something about that, and then of course about the doctors' fees. Now, the Commission feels, after studying this problem for 2½ years, that it's got to be addressed: Cost, access, and quality, all together. And we might as well get on with it, because what's going to happen if we don't?

Well, we double our cost in 5 or 6 years, triple them in about 10 to 12 years. And if we take care of the access problem, we're going to increase those costs unless something is done with the system.

So, we need a systemic approach to begin to address these problems—and it'll take some time to do, of course, no questioning that. Let me tell you, if we want to do something about cost we better address quality right away. They are connected.

They estimate that 80 percent of daily medical care in the country has never been analyzed properly to find out what really works, what really doesn't, what is effective; 80 percent.

Now as a result of that, the commission found, and we had testimony from the editor-in-chief of the New England Journal of Medicine, probably the most prestigious medical journal, that 20 to 30 percent, 20 to 30 percent of all things done by well-meaning physicians in good hospitals is either inappropriate, ineffective, or unnecessary.

Well now that 20 percent of the health care costs of the Nation would be, and that's a big savings right there; 20 percent. And he says it's 20 to 30 percent.

The RAND Corp. has studied this, and they indicate that about 14 to 32 percent of each of the operations they studied were inappropriate and unnecessary, 14 to 32 percent.

Dr. Donald Berwick of Harvard, an expert on quality control, says that without quality control, this number might go up to as high as 30 to 40 percent. Now that's shocking.

So we're going to have to begin to research these things. We need to get this knowledge out in the form of guidelines, which the profession itself recognizes. I think this committee may be comforted to know that the AMA has already agreed with this in effect by now contracting with the RAND Corp. to do research in this area.

Now if we could begin to do that, that's going to carry an awful lot of weight on costs. It'll take some time. But it can be done and we've got examples where it works. For instance, in a study in Maine, when Dr. John Wennberg did the study there on prostatectomies, the doctors didn't realize the death rate was as high as it was. It was much higher than they had thought.

They didn't realize what was happening with much more permanent impotence than they anticipated, permanent incontinence, and, of course they were having the need to repeat those operations.

As soon as this information was developed, they began to educate the physicians, and there was a drop of 15 percent right off in

those operations in the State of Maine. It can be done, but we can't just sit back and do nothing.

We've got to really make a national effort. And we're not just asking the Federal Government. We're talking about a partnership of the private sector and Government, together. It can't be done by one or the other alone. The Government pays about 40 percent, and the private sector about 60 percent.

And industry is ready to address the problem, I assure you, because health care coverage is now the highest uncontrollable cost they have. Lee Iacocca said it's now costing $700 a car. General Motors last year processed 40 million health claims. An uncontrolled cost, and it's going up and up.

Now, let me turn to quality. I think it's tied together so closely we can't just discuss access alone. Savings from quality improvement—we simply have been unwilling to address it in this Nation properly.

Now some of the States are working, on changes in malpractice. The malpractice problem has pervaded medicine in this country. The problem is so extensive, there is no telling what that has added to the cost of the delivery of care.

In lab tests alone, it's estimated that there are many billions of dollars of unncessary testing—just in lab tests. Not in all the other procedures.

The commission recommends that we look to see what has been done by the States and where it has worked and begin to make those changes more widespread. One such change is instituting strict criteria for expert witnesses. With witnesses, that's all they do, and they're not qualified in many areas they testify in. There should be better criteria.

Strengthening the standards of negligence is another area. We could also limit punitive damages in contingency fees and encourage mediation and arbitration as alternatives to lawsuits.

Those two problems—quality and malpractice—must be approached if you're ever going to do anything about access and cost in this Nation. Otherwise we're fooling ourselves.

Now we do think that the individual should be given more responsibility for its health care in this country. And we would put that burden on the individual. Now there are three ways the individual could get his health insurance: through his employer, which is currently done and should be expanded. Maybe we would phase in small industry, but that ought to be looked at. Now, industry could decide either to do that or we would establish the universal access program which would be administered by the State.

You, in effect, would meld Medicaid into it. So it's not the same as Medicaid, but everybody in that State under 150 percent of poverty could be covered. And then the second way the individual gets insurance is, if he can afford it and he doesn't get his insurance from an employer, he could pay for it himself.

We think there should be negotiations with providers, perhaps with bids in each State, to begin to get costs down for the people in the universal access program. We think this type of approach could be the way to administer a basic package of care for everyone.

This generally is what the commission feels. Thre are many details we'd like to work out with the States. There are some, of

course, that we're still working on with experts to try to get some problems solved. But we would like to work with the committee, if we can, and your staff.

Now, if the Chair would permit, I would like John Sweeney to say a few words.

[The statement of Mr. Rogers follows:]

Testimony of Paul G. Rogers before the Health Subcommittee of the House Ways and Means Committee, April 6, 1989. Hearing on "Health Insurance and the Uninsured."

Mr. Chairman, Members of the Committee: It is indeed a great pleasure to appear before the Subcommittee on Health on such a critically important subject, health insurance and the uninsured. I come before you as Co-Chairman -- with former Governor Robert Ray of Iowa -- of the National Leadership Commission on Health Care. Ours is a bipartisan, private commission which spent the past two and a half years examining the problem of access to health care and the related problems of the cost and quality of care.

A group of concerned citizens formed the Commission in 1986 to address what it believed were the three major problems facing the nation's health care system -- access, cost and quality -- and propose workable solutions to these difficult issues. The Commission brought together a distinguished group of leaders from many areas -- health care, business, law, economics, politics, ethics, and labor. These are the very groups that we believe must join with the government in achieving effective solutions to the difficult problems that beset our health care system.

We believe the concern your committee expresses by holding this hearing could not be more timely, because serious strains in the health care system are raising the frustrations of all who participate in it. In fact, a new survey by the Louis Harris organization shows that Americans, "frustrated with rising costs and growing numbers of uninsured," have shifted from years of general support of our health care system to serious criticism of the American system. The Harris poll found that eighty-nine percent of Americans believe there is a need for fundamental change in our health care system, and that far more Americans than British or Canadians think financial barriers keep them from getting the health care they need.

The Harris organization questioned over 1,000 people in each country -- the U.S., Canada, and Britain. Over seven percent of Americans surveyed said they faced financial barriers to receiving health care, while less than one percent in Canada and Britain believed they faced such barriers. The poll found that low-income Americans went to the doctor less frequently than did poor Canadians. Two-thirds of the Americans who said they did not obtain care for financial reasons also said they had health insurance, implying that their coverage was inadequate. In fact, twenty-four percent of the Americans polled said health care should have the highest priority for new government spending. Sixty-one percent of the Americans polled said they would prefer a Canadian-type health care system.

The conclusion reached by the president of the Harris organization is that the poll confirms "all of one's worst fears about the American system. We have the most expensive, the least well-liked, the least equitable and, in

many ways, the most inefficient system." This stunning outcome to a major survey reinforced the findings of our Commission. We not only found the problems larger, more urgent and deep-rooted than we had supposed, but we found them so tightly intertwined that a solution must respond to all three interrelated problem areas rather than try to pull them apart and solve them separately.

Thus the Commission called for providing universal access to a basic level of health services while controlling escalating costs and resolving serious problems which exist in the quality and appropriateness of care. The Commission believes it makes no sense to provide universal access to a system where costs are out of control and the quality of much of the care is riddled with uncertainty. The Commission explicitly rejected a piecemeal approach and in its place supported a long-term comprehensive strategy carried out by a new public-private partnership which can control costs, provide universal access to a basic level of health services, and improve quality.

The Commission's Universal Access (UNAC) plan requires individual Americans to take responsibility for having health insurance for a basic level of health services. There would be three ways to obtain such coverage: employer-provided coverage, individual purchase of health insurance, or public coverage through the UNAC program. The proposal would control costs through wider use of innovative purchasing of care, through competitive purchasing by the new Universal Access program, and through greatly expanded research, technology assessment, and guidelines on the quality and appropriateness of health care. The plan would build a system for continuously improving and updating the quality of care, by conducting expanded research to develop practice guidelines which would eliminate much of the unnecessary care now being delivered, saving money and improving quality at the same time.

The present system is untenable for a number of reasons. First of all, it is too expensive, wasteful, and inequitable. We believe all Americans should have access to basic health services just as they have access to public education. As Commission member Uwe Reinhardt of Princeton University said: "In a civilized society, every member of society should have access to a basic package of health services." As long as one out of every four Americans is either uninsured or underinsured, the Commission believes our nation cannot call itself healthy.

The most shocking part of that story is that one-third of the uninsured, over 11 million people, are our children. They represent the future of our society. And we know that the uninsured wait until they are sicker than the rest of us to get help. That means that millions of our children become ill without the basic preventive services all young people should receive, starting with prenatal care, one of the most cost-effective ways we know of to deliver care. They then are unwilling or unable to turn to health care providers for help until they are more seriously ill than the rest of us. A recent Robert Wood Johnson Foundation study in the District of Columbia found this to be true for children living just a few blocks from this building.

We must provide these young people with basic health care services. But if we improve access to care and do nothing else, our costs will just escalate

out of control even faster and our quality of care will continue to be riddled with uncertainties. We have tried piecemeal solutions in the past, and they have not worked and will not in the future. We must have a systemic solution to these three problems.

Here is what our Commission proposes. First, we need a new public-private partnership that will provide access for all to a health care system which will deliver cost-effective, appropriate care. Government cannot and should not have to do it alone. Neither should private industry. Our model calls for a shared responsibility to finance care for the currently uninsured, while retaining a significant role for the states and private insurance companies. At the same time, the system is structured to foster competition and innovation in the quality and efficient management of health care services. The plan calls for a strong education campaign to encourage patients to adopt healthy lifestyles and to inform patients, providers, and payers about guidelines for appropriate care to help them make better decisions about treatment.

We can begin by making better use of the existing system of private insurers and encourage all employers to provide health insurance to their employees. Employers who chose not to provide coverage would instead have to pay a fee of about nine percent into the Universal Access or UNAC program. Everyone not covered by an employer or an individual health insurance plan would receive care through the UNAC plan. This plan would be paid for by a small health insurance premium of about half of one percent of earnings up to the Social Security maximum which all Americans with incomes over 150 percent of the federal poverty level and all employers would pay.

This system would be decentralized and administered by state agencies which we recommend be expanded to include representatives of payers, providers, and patients. They would be responsible for negotiating for the purchase of the basic level of services set forth by enabling federal legislation. The agencies would be encouraged to pay fair compensation to providers and to purchase care efficiently.

They could purchase care in part based on the practice guidelines developed as a result of the National Quality Improvement Initiative called for by the Commission. Under this initiative, we would greatly increase research on the appropriateness, effectiveness, and quality of care and publicize the results widely to help patients, providers, and payers assess treatment. We would eliminate much of the unnecessary and possibly harmful care that is now being provided, which is a large figure. In fact, the editor-in-chief of the New England Journal of Medicine, Dr. Arnold Relman, has estimated that 20 to 30 percent of all things done by well-meaning physicians in good hospitals is either inappropriate, ineffective, or unnecessary. Researchers at the RAND Corporation, who have assembled panels of physicians to examine a number of our most common and costly operations, have found that between 14 and 32 percent of each of these operations were unnecessary.

We also know that our quality assurance systems in medicine are inadequate. In testimony before the Commission, Harvard's Dr. Donald Berwick, an expert in quality control, pointed out that in service industries

(and health care is one of those), the costs incurred due to the absence of adequate quality controls -- including the resulting errors, rework, and poor outcomes -- could be as high as 30 to 40 percent of total operating costs.

It will not be easy to change behavior, but it can be done. When a team of researchers from Dartmouth University looked at ten years of prostatectomies in the state of Maine, they found a far higher rate of death, permanent impotence, permanent incontinence, and need to repeat the operation than Maine doctors had been aware of. And when they told the doctors in Maine of their findings, the number of prostatectomies in the state dropped 15 percent. Solid research by well-trained physicians will be listened to.

If this information were just developed by government for use in its own programs, as some are suggesting, that would only lead to cost-shifting to private payers and would not affect care given to all Americans. We need change nationwide, and to be effective it must be a public-private partnership. This will spread widely the benefits of our proposed investment in quality care, and it will hold down the possibility of cost-shifting which has plagued this system in the past.

A major impediment to economical, high quality care is the current system of malpractice litigation. This litigation has driven up the cost of medical care. Fear of malpractice suits encourages defensive medicine, with providers performing additional procedures to protect themselves against lawsuits. Several interesting proposals have been adopted in states and localities that we believe could be adopted nationwide. Our report lays out those strategies we believe will help solve the malpractice problem. They include instituting strict criteria for expert witnesses, strengthening standards of negligence, limiting punitive damages and contingency fees, and encouraging mediation and arbitration as alternatives to lawsuits.

Since the Commission completed its report, the Physician Payment Review Commission has released its 1989 recommendations. In addition to calling for a restructuring of physician fees along the lines of the Hsiao study at Harvard, the outlines of which our Commission was aware of and supported, the recommendations included a call for a national expenditure target. Our report noted the possible utility of such an approach. We would urge that you take a careful look at this proposal as an important way to control costs.

I would urge you to consider a system like that devised by our Commission, which provides universal access to basic health care, but only in a new system that also brings costs under control and improves the quality of care. Our Commission believes that providing access to health services to all Americans is a basic social good but that it should not be done in the current climate, with costs out of control and uncertainties deep within the quality of care. We should provide universal access only to a system that provides appropriate, cost-effective health care. We know how to do it; we only lack the will to do it. Increasingly, as the work of our Commission has shown, leaders of the private sector want to work with the government to bring about the needed changes in our health care system.

The testimony is presented by Paul G. Rogers, Co-chairman of the National Leadership Commission on Health Care, an attorney with Hogan & Hartson, and a member of Congress from Florida from 1955 to 1979 and Chairman of the Subcommittee on Health and the Environment from 1971 to 1979.

Chairman STARK. Thank you.

Mr. SWEENEY. Just briefly, Mr. Chairman and members of the subcommittee, I just wanted to state that, as the committee well knows, the labor movement has long called for a national health care system as the way to solve our triple problems of the climbing access problem, skyrocketing cost and uncertain quality. And while the commission's proposals are not national health insurance, they represent a significant move in the right direction.

Ultimately we believe that a single financing mechanism will be necessary to reach our goal of providing affordable quality health care to all Americans. From the labor movement's perspective, the commission's most important proposal is the strategy for providing all American citizens reliable access to much needed health services at an affordable price.

Uninsured Americans now number in excess of 37 million, and make up over 17 percent of the nonelderly population. Despite 6 years of national economic recovery, we cannot simply grow our way out of this problem. The evidence makes clear it will continue to get worse. The commission's report makes clear that much of the medical treatment, even in the best of institutional settings, is of distressingly low quality; between 10 and 40 percent of all procedures performed may be unnecessary, harmful to many Americans and wasting billions of dollars.

The commission's proposal is to establish a national clearinghouse on quality to evaluate and research the efficiency of technology in medical practices, is a giant step forward in establishing the medical standards necessary to bringing health care costs under control. Many experts believe that the cost savings would pay for universal health coverage.

Thank you.

Mr. ROGERS. And Mr. Chairman, thank you. May Dr. Simmons just make a short statement?

Chairman STARK. Certainly.

Dr. SIMMONS. Just to reiterate the main statement that Paul made, Mr. Chairman, it may be that the most important finding our commission came up with is that the three problems of cost, quality, and access were inextricably intertwined. Therefore, any approach that did not understand that and did not deal systemically with that was doomed to either aggravate the problem or possibly fail.

So we at no point said that solution of the access problem in isolation would be in the Nation's public interest. In fact, it could be a disaster; because then costs could continue to rise and everybody's access would be adversely affected. So what we are advocating is universal access to a basic level of health services which are federally determined, but only coupled with a strategy that deals with a very serious cost, efficiency and quality problem; that deals with the malpractice problem, and that deals with the escalation of costs.

Chairman STARK. Thank you, gentlemen. I am going to ask a little bit about the financing side. And I do not, for a minute, by concentrating my inquiry in that area, minimize the importance of quality and access; although I tend to find access more closely related to income levels than quality, certainly.

Mr. ROGERS. We would agree.

Chairman STARK. But the premiums on employers who provide—the ex-premiums, if I may—are basically, in the Darmanesque vocabulary of today, very much duck-like and, in fact, our staff tells us are taxes and would have to be administered through the Internal Revenue Code.

Is that your understanding?

Mr. ROGERS. Well, we are working with experts now to see if there is some way. We call them premium and fee; but it is additional money.

Chairman STARK. We tried that in the Gradison catastrophic legislation of last year. A duck is a duck.

Mr. ROGERS. So however you want to call it, if you are going to cover additional people, it is going to cost some money.

Chairman STARK. We could not sneak it by Jimmy Roosevelt. [Laughter.]

Mr. ROGERS. But what I am saying is, if we get to the quality, you may not have to raise many taxes.

Chairman STARK. Wait, just for a minute; I want to separate quality if I may here just for the technical part of this; that if in fact, if we were to attempt tomorrow to adopt your plan, we are still basically faced with doubling the Medicare cost. You are talking about 0.5 percent on both sides of the equation for those in the program; and Medicare is now what—1.35, 1.45. So there is a big kick there.

Mr. ROGERS. It is a 0.6 cost.

Chairman STARK. So, you are adding a point on top; so that is a 70 percent increase. And that is big. And for those employers who have no insurance, to add 10 percent onto their payroll costs, or 50 cents an hour, 40 cents an hour; well, you have seen the barrage we are getting now on minimum wage increases. I just want you to understand the political enormity of these X and Y premiums.

In other words, I am not sure that this committee, much less the whole House, would agree to that, even if we said it a different way; and said, "Are you willing this year to double the payroll tax, and are you willing to add 50 cents an hour to the minimum wage," which is basically what you are saying, "to provide this?"

And I think the answer is that we are not ready for that politically. That is saying that a much different way, I know. But it really is the flip side of your proposal; is it not?

Mr. ROGERS. No, I understand the difficulty; and it is a problem; no question about it. This is just one suggestion that the commission proposed. Now, you can go any other route. You can also cap, try to control costs by capping them.

Chairman STARK. If the commission would join with us, and as you indicated in your testimony—we have heard from American Airlines; we have heard from Chrysler; we have heard from what I would like to call the responsible employers—both with negotiated or bargain plans; and some who have, if you will pardon the expression, John, nonunion employees; who are saying, "It is only fair." If we could get the unions to say, "Part of the minimum wage increase ought to be benefits. We don't need a dollar-an-hour increase, or $1.50. We will take $1 cash and 50 cents benefits."

I mean, some of their members don't get anything. If we could build this coalition, we have got to pay for it. This is not the cost just to a few people, because some people are overpaying. Some people are now doing what, in my opinion, is the proper thing; I don't mean to say right from wrong. And the rest of the cost is going to real estate taxes and higher costs, because we have much more acute problems because we postponed the care. The cost is there.

Now, you have suggested a much fairer way of doing it. And if we could somehow broaden this coalition that you have started and not tiptoe around—and quite frankly, I would suggest that that is what we did, for whatever reason, as we wove the fabric of the catastrophic bill, which has got some objections now.

Had we somehow been much more direct with, whatever we called it, a fee or a tax, from the very beginning, perhaps we would not have had some of the reactions that we are having. The real problem, as I see it, is going to be getting particularly the small business person who is going to raise the scepter of competitiveness and the scepter of bankruptcy, and all those other things to agree with us. And I am sure that you all know that we will hear that cry loud and clear. We need to be able to address that politically. And we need your assistance to do that; I just urge you to continue your work; to be much more zealous and missionary in the way you present this, because it is what we have to do; and I do not know how soon we can do it.

Mr. ROGERS. We understand that, Mr. Chairman. And I think the points you made, of course, are legitimate. And we would be glad to work with you and with the committee, and see what we can do to try and be helpful.

I might add that we have already met with many groups, including AARP, National Association of Manufacturers, the Business Roundtable, and other consumer groups, briefing them on this. And the reception so far has been quite good. So I think if we could work together, hopefully, we could get some approach that would work.

Dr. SIMMONS. Mr. Chairman, the interesting thing that we have been finding, and let us just stick to industry for a minute, though we have been working with all the key groups, is that we are beginning to see in industry as understanding that maybe there would be a new premium or a fee; and it obviously would be better not to do that.

But then we pose the question, "Alright, if not this, do you see any other possible means, over the long term, to control this critical and rapidly growing problem?"

Then they say, "No, that is right."

This is a reasonable way to proceed, if we are ever to get control of these problems. And I believe that a longer term look now is what we are beginning to see, actually throughout the private sector, big and small business. And I believe we can build on that with your help. And again, we are not looking for a purely governmental solution.

Chairman STARK. I suspect my help would be not endorsing the plan; is that what you are suggesting?

Mr. ROGERS. What?

Chairman STARK. My help would be comprised of not endorsing the plan; is that what you are suggesting, Doctor?

Dr. SIMMONS. We will do it quietly. [Laughter.]

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. Your entire report is extremely helpful to us; and in highlighting the question of quality, which I want to do in a comment in a moment, I am not in any way trying to take away from the other aspects of your very comprehensive and very valuable suggestions.

I think we, with your help, are reaching a point of growing consensus about the importance of expanding dramatically our research into what works, into the question of effectiveness or quality, bringing to bear the resources available not only from the data banks of the Federal Government, but from private insurers as well; and also involving, throughout the entire process, the medical profession. Whatever comes out of this will only be useful if it is accepted, if the physicians help to develop it and then feel a stake in implementing it later on.

Mr. ROGERS. We agree with that.

Mr. GRADISON. And your points are extremely valuable, and the basic principles have been incorporated into a piece of legislation which Chairman Stark and I have been working on. And there is counterpart legislation, very similar in principle, although slightly different in specifics, which has been introduced by the leader of the Senate, Senator Mitchell of Maine, along with, among others, Senators Durenberger, Chafee, and Heinz.

The administration has also signaled that this effectiveness issue is one which has their support and has allocated, in their budget proposals, additional funding for the purpose.

So I just want to thank you for the emphasis which you have placed on that area. It often is not focused on. I don't mean people to say that it is unimportant, but a lot of groups just don't focus on it to the extent you have. And I think there is an excellent chance of action on it this year; in large part because you have put the weight of your 2½ year study behind this. And I want to thank you.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mr. Gradison.

Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman. I would ask this question of anyone on the panel.

Did the commission study or analyze the relationship between increasing health care costs and the make up on medical equipment and supplies in the health system?

Mr. ROGERS. Well, the technology, of course, brings additional costs, as we introduce new technology. Often, what will happen as new technology is introduced, is that it becomes duplicative of current technology. But eventually, when the profession becomes accustomed to it and feels comfortable with the new technology, it then supplements the older methods and then begins to pay for itself.

So there is generally a first period when technology is expensive. And that is something, too, that we can evaluate in the program that we had suggested on quality; that new technology be evaluat-

ed to make sure that we know exactly what it will do, the purposes, and its value, before introducing it.

Mr. COYNE. What about, everyday hospital supplies and costs of that nature? Did the commission look at that as a reason for the escalating costs?

Mr. ROGERS. I do not know that we went into that specific detail; but of course, that is true. And as you know, many hospitals have been working togethere or purchasing of supplies to try to reduce their cost, to get a better price.

Dr. SIMMONS. Mr. Coyne, there is an aspect of that that we did get into, that we think is very important. And it deals with the everyday operation of the health care system, including how you order, store, disseminate supplies; how you do lab tests, record them, disseminate the results. And there, the testimony of some experts in the field was extremely revealing. And one in particular was by an expert at the Harvard Community Health Plan, Dr. Donald Berwick.

And the point that he and others are beginning to make, including people from Bell Labs and others, such as the Jurand Institute, is that there is a second very serious problem in the health care system, and that is in the lack of quality assurance systems. The point they are making is, if you go in and look, you will find 30-percent error rates in reporting of lab tests, 6 month delays in records coming on line, so that a second admission before 6 months has no benefit from the earlier data and, therefore, things have to be repeated.

They point to one thing after another, and the critical point they make is that if you look at the experience of any other service industry, of which the health care system is an example, when you do not have those systems, you can reasonably assume that you are wasting between 20 to 40 percent of your total costs. That is not an unreasonable assumption, according to experts in the field.

In the health care system, we have spent virtually nothing in quality assurance. Most of our approach is in inspection which is, though important, completely inadequate in its own right. And that is a problem that our commission is trying to highlight, and other experts around us are also.

So there are two problems. One is in the quality and appropriateness of care, or lack of knowledge, the issues of outcome; is it worth the cost? And that is big. But there is a second, possibly as big or bigger, and they are not necessarily the same. And it is how we use the equipment, how effectively we use it, report it, and respond to it.

Mr. COYNE. On another subject, in trying to determine what would be good national policy, is there any State that has attempted to address this problem on a that level?

Mr. ROGERS. Arizona might be looked at. I think you might like to look at Arizona.

Mr. COYNE. Arizona? Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman, and I thank the panel for your years of work on this important issue. I, too, agree that we need to take a systemic approach. And I very much agree that we

need research on what is effective and what is appropriate, both to eliminate the cost of those things that are neither effective nor appropriate; and just as important, to establish accepted patterns of practice that can be used to control the costs of malpractice premiums and malpractice-driven medical decisions.

And I think your contribution in that area is of enormous importance; and if we do not do that research, we will never be able to provide access to quality care. But there are two things that you do not mention that I want to ask your opinion about, and whether or not you discussed and considered them. And one is the administrative costs of our current publicly funded systems.

I think for us to move further into mandated care, whether we mandate it in the private sector or the public sector, without an understanding of what is happening to the administrative component of health care costs in America, would be unwise.

Some of the things that I have read recently indicate that as much as 25 percent or more of the cost difference between the United States and the Canadian system is directly attributable to administrative costs in America. In working closely with my Connecticut VNA, a micro-part of the health care service system in America, I have seen the number of home care visits a nurse can make in a day decline from six to four.

I mean, we are talking about a mammoth decline in productivity, with the consequent dramatic increase in administrative overhead; specifically because of the increased paperwork they have to deal with, without doubt.

Now, if this is true in the hospital sector, and I know it is to some extent; and I have sat with physicians who show me eight pieces of correspondence about a $15 reimbursement for a home care visit worth $15. I mean, I am telling you, this administrative cost issue is not little; it is big.

Did you talk about it? Did you evaluate it? Have you thought about what kind of research we should do to find out about it?

Mr. ROGERS. Yes, we did look at that and heard from experts, and we agree with you. It is tremendous cost that must be addressed. We think the universal access program that we propose also would be helpful in cutting down paperwork. But I agree with you a hundred percent.

Mrs. JOHNSON. That must surely be one of the benefits, or it will not be adoptable. And I look forward to working with you on helping to refine the kind of research that we need to do to get very precisely at those costs, not just at the top in Government or even at the top in hospital administration, but right down to all those VNA's and office requirements in bookkeeping and correspondence and so on that we are loading into the system.

The second issue I want to raise I hope will not offend my chairman or other members of the committee.

Chairman STARK. As long as we do not run out of time.

Mrs. JOHNSON. It is not a popular issue to raise, but since I agree with you that the approach that must be taken is systemic and the solutions must be realistic and practical, I think it is imperative to look at this issue of effective and appropriate and outcomes at the extremes of the health care spectrum.

Did you do any analysis of the cost of, for instance, neonatal care for very fragile infants or, conversely, of intensive interventions in the case of very old, frail elderly? Would you recommend that your effective, appropriate research include an analysis of the medical investment in those kinds of extreme settings? And I ask that question because I personally am concerned within our own appropriations budget process about the money we are allocating to new neonatal facilities for newborns in America versus the money we are allocating for prenatal care, inoculations, preventive care for children in the first 5 years of their life.

Mr. ROGERS. Yes,we did. We looked at both of those problems. Of course, those are the two areas where the costs are the highest.

Mrs. JOHNSON. That is right.

Mr. ROGERS. And research does need to be done. Also, we need to do education programs and preventive programs that prevent the neonatal problems. Many of those prolems could be prevented by getting the mothers coming in, by proper diet and that sort of thing, which would not be that expensive. It would save those tremendous neonatal costs.

Then, we need an education program, and I think this is beginning to grow in the Nation, but it needs to be accelerated rapid. And that is to educate people about that these costs that are attendant to the last stages of life. If a determination is made, we ought to encourage the living wills, the process, so that people can make those judgments that they do not want to continue to be maintained when there is really no significant effort that would continue their lives in any reasonable sense of living.

I think that needs to be heavily stressed.

Mrs. JOHNSON. Thank you.

Mr. SWEENEY. Mr. Chairman, if I may go back to Congressman Coyne's question about the State examples, was your question regarding cost and quality, or was it also regarding access?

Mr. COYNE. Access, universal coverage. And I am reminded by Congressman Donnelly that Massachusetts——

Mr. SWEENEY. That is what I thought. I think we misunderstood the question. We have the Massachusetts example on the minimal mandated coverage.

Mr. DONNELLY. Gentlemen, you are very welcome. I apologize for being somewhat late. Mr. Rogers, you are especially welcome. You are legend in this institution, and we appreciate your input. I am glad, John, you brought up the example of Massachusetts, the State that I represent. We are only one of two States in the Nation that provide universal health care coverage for all of our people, the other being Hawaii, which for years has provided its citizens, irrespective of their economic situation, with access to quality health care.

I do not think it could be done on a State-by-State basis, but I thought it was important, at least for the Commonwealth of Massachusetts, that we have a responsibility to take care of our own. And we went ahead and did that, and now we are attempting to grapple with the enormous financial issue after making a public policy decision.

Let me just ask the members of the commission about the whole issue of cost containment. I do not really think we are going to be

able to put together a coalition of folks to deal with the $37 million people that are uninsured unless we, at the outset, deal with the escalating and scandalous increases in cost in the health care delivery system.

Did you talk about things like prohibition against balance billing, closing underutilized institutions as part of your recommendations, I mean specifically? We did that in Massachusetts. When we asked the citizens of Massachusetts to assume this cost and the business community of Massachusetts to assume this cost, we also said to them that we were going to bite the bullet in terms of increased cost in the provider system. And we did that by prohibiting balance billing, by putting together a mechanism that would close down underutilized institutions.

Don't you think that that same sort of commitment is necessary on the national level if we are to proceed ahead with some of your recommendations?

Mr. ROGERS. Well, I think we are going to have to look at every possible effort to hold down costs that is reasonable. Now, as you know, we do propose that employers cover employees. That is one technique. And, of course, that will cover millions of the 37 million that are basically denied access.

Now, that is shifting to the private sector, but I think the private sector will be willing to do this, if we can show them that, as you say, we are going to take those steps that will hold down costs. And one of the most practical ways is to get at this quality problem, to develop guidelines, and also to do something about malpractice.

I think we could really get the cooperation of the medical profession if we will do something about malpractice, because a man or a woman who is a doctor is simply going to do defensive medicine as long as they can be sued in astronomical terms.

So all of these tie together, and that is why we say the approach should be systemic. But I agree that those things do need to be done.

Mr. DONNELLY. Well, the physicians are going to receive some sort of relief on the malpractice burden—

Dr. SIMMONS. On physician reimbursement specifically, let me just tell you how we handled that. First of all, we noted that there has to be reform of physician reimbursement. And we at the same time recognized that at the same time we were at work, PhysPRC was actively involved in exactly this question at the direction of the Congress. So we have been working with PhysPRC. In fact, we have briefed them about our findings, and they have briefed us. And we note in our report that the whole issue of expenditure caps, when further defined, which PhysPRC is now in the process of doing, may well be a useful adjunct. But the major point we make is whatever Government chooses to do, it could result in a cost shift if it is not also done by the private sector. Therefore, both parties should consider how an action by either party affects the other. And certainly physician reimbursement is one such issue.

So we handled it by saying we note the PhysPRC analyses and recommendations and, when finally refined, they could well be appended to our approach. They could be applied to the private sector as appropriate, so that there is a uniform approach so that you do

not just shift the problem from Government to the private sector. And that is how we handled that specific issue.

Mr. DONNELLY. You know, when you look at our entire health care delivery system for 240 million Americans, if in your wildest imaginations you were tempted to set up a system that was inefficient, that did not provide the access to care, that just did not work well, I think you could use the United States as a model. That, I think, is a condemnation of a whole series of decisions and factors.

My point is from the Massachusetts experience, if we are—and we ought to go ahead and develop a system to provide access to quality care for these 37 million American citizens, at the same time we have to address the issue of cost control. We cannot continue to feed that enormous cash cow out there and just provide continual dollars to assist a system that is scandalously inefficient. Because if you need to get the support of labor and business and the taxpayer, they are just simply not going to go along with it.

What we did in Massachusetts is tell those three entities that they were going to participate in a system to provide coverage for all of their people, many of them less economically disadvantaged than themselves, but we are also going to make the delivery system more efficient and the folks in the delivery system much more cash conscious and cost conscious.

Just quickly, Paul, you brought up the issue of malpractice insurance, and in Massachusetts it is scandalous. How do you suggest that we solve it?

Mr. ROGERS. I think we should begin to project on the national scene programs that have worked in States, to get a national consciousness that we must address this problem. I think it would be well, where we feel it would be appropriate, for the Federal Government even to take action in those areas that it is appropriate to do so. And you would have to study that to see which effort is most appropriate, but it is important to begin that movement. It has got to be done eventually if you are ever going to get costs down.

I agree with you 100 percent. I think that is the best way to do it, to get the examples, see how they have worked in the States that have already started. There are about, I think, 14 to 16 States. Look at those, which is what we did, and then begin to use those examples to see what can be accomplished. We might have to go national to get it done, because just leaving it State by State is going to take too long. We are doubling the costs in 5, 6 years.

Dr. SIMMONS. Mr. Donnelly, on our approach to malpractice, just as background, we had the dean of the University of Virginia Law School, Dick Merrill, on the commission, and he specifically helped us draft the proposal that you will see in our report. There was another proposal laid out during the commission's deliberations which has some real merit to it and which you may wish to consider.

If you remember back to the legislation that Senator Bennett passed, the PSRO legislation in 1968, there was a Federal preemption in that statute that said if doctors follow the guidelines and standards that they professionally develop on the basis of good science, they are immune from a malpractice suit. And several of our commission members felt that made real sense to revisit that as a possible strategy in malpractice. That, obviously, would impact sub-

stantially on the defensive medicine side. You would not have to practice defensively because your own profession, on the basis of good science, has developed guidelines and standards that say, look, this is all we need to do in this instance. We do not need to do more or, obviously, less.

Then to get to your cost containment question, the commission could not agree with you more that we must contain costs. I think what a lot of people are missing in our proposal is that there is a very strong cost containment strategy in this proposal. It consists of sharing of costs on the part of beneficiaries. It consists of an approach to the malpractice. It consists of better science, guidelines, standards, and removing the lack of knowledge we have. And there is a strong negotiation process by these new State entities that we are saying should be set up. There is going to be substantial economic leverage, a good basis of information to make payment decisions because we know what makes sense and what does not, and the ability to negotiate with the providers, hospitals and doctors.

So putting it all together, there is a very substantial cost containment strategy built into this proposal, and it has not been adequately understood to this point by enough people.

Mr. DONNELLY. My time is expiring. The chairmen of the 1980's are not as liberal with their time as the chairmen of the 1970's were, Mr. Rogers. But you do all agree, could I say fairly that you all agree that the Feds have some role in dealing with the malpractice crisis?

Mr. ROGERS. Definitely.

Mr. DONNELLY. And would that include a limitation on liability?

Mr. ROGERS. It could.

Mr. DONNELLY. It could. Thank you so much.

Chairman STARK. I want to thank the panel very much. I think that the whole concept of your organization, both in the way it is organized and the way it is moving ahead, will be very helpful to us as we try and work together to solve this problem. Thanks very much.

Mr. ROGERS. Thank you very much, Mr. Chairman. You are very generous and kind.

Chairman STARK. Our next panel consists of Ms. Dana Hughes, the assistant director for State and local affairs of the Children's Defense Fund; Michael M. Barch, the vice president of Indigent Care Task Force, accompanied by John Billings of the District of Columbia Hospital Association; and Mr. Peters D. Willson, director of government relations for the National Association of Children's Hospitals and Related Institutions.

We welcome the panel to the committee and ask that you summarize or expand on your testimony, the prepared version of which will appear in the record in its entirety.

Ms. Hughes, would you like to proceed?

STATEMENT OF DANA HUGHES, ASSISTANT DIRECTOR FOR STATE AND LOCAL AFFAIRS, CHILDREN'S DEFENSE FUND

Ms. HUGHES. Thank you, Mr. Chairman. I am here representing the Children's Defense Fund and want to say that I am pleased to be here. I also want to thank and commend the committee for hold-

ing these hearings to focus attention on one of the major threats to children and their families in this country: lack of health insurance.

I am here to talk about one segment of the problem of uninsuredness, but it is not an insignificant one. Of the 37 million Americans who are uninsured in this country, approximately one-third are children. In 1986, nearly one out of every five children living in a family was completely uninsured. Uninsuredness in this country among children is not only high but actually on the rise.

Between 1980 and 1985, the proportion of children under the age of 18 who were covered by an employment-based insurance policy fell by 6 percent.

As disturbing as these figures are, they actually mask the differences by family income, race, and parents' employment status, variations that are actually critical as we design remedies to uninsuredness in this country. We have recently completed an analysis of Census Bureau data that looked at these differences, and I want to highlight some of those findings for you.

As one would expect, insurance status is associated with income. As family income rises, the proportion of completely uninsured children declines. In 1986, 18 percent of all children living in families were uninsured, compared to 32 percent of children who are poor. However, a considerable proportion of children in this country from moderate-income households are completely uninsured. Among children living in families with incomes between 100 and 200 percent of the Federal poverty level, nearly a third were completely uninsured in 1986.

Children in working families are even more likely than those in nonworking families to have no health insurance, especially when they live in low- and moderate-income families. In 1986, over 19 percent of all children in working families were completely uninsured, compared to 42 percent of poor children in working families. This phenomenon results from at least two factors, one being the erosion of employer-based health insurance for families. The second factor is that children living in working families, particularly those in moderate-income working families, are far less likely to be eligible for the Medicaid program.

It is also important to note that moderate- and low-income children in working families are also less likely to be insured because their employers are far less likely to assist in the cost of the insurance premium. In 1986, nearly 40 percent of all employer-insured children in working families were covered by a plan that reportedly paid all of the cost of coverage. However, only 27 percent of children in working families had such coverage. Thus, employer subsidization of the cost of families' plans is most commonly available for those families who least need it.

There are enormous disparities among race and insurance coverage among children, and I only want to note one, which is the disparity between children in families that work. While 29 percent of all black children in employed families were completely uninsured in 1986, only 17.5 percent of white children were uninsured. Similarly, while 70 percent of white children in employed families had employer coverage, only 49 percent of black children had employer coverage.

The cause of this disparity in insurance coverage among black children living in working families is probably because the black children with working parents are far more likely to have two parents working in low-wage jobs rather than one parent working in a high-wage job.

The Alan Guttmacher Institute has produced a ream of evidence to support the notion that women of childbearing age also face the risk of uninsuredness, and so I will not repeat those data, except to say that in 1985 as many as 9.5 million women of childbearing age had no health insurance, public or private. This uninsuredness is a serious problem among mothers, as well as children.

Numerous studies show that health insurance is a significant determinant of health care utilization. National survey data reveal that low-income uninsured children have a lower likelihood of, and a significantly lower average of, visits to physicians. When adjusted for health status, uninsured children remain more likely to have no physician visits in a year. Poor children with Medicaid coverage, however, are far more likely than uninsured poor children to have a regular source of health care and to visit a physician within a year. Medicaid recipient children use services in a pattern similar to that of their affluent, privately insured counterparts.

Medical indigency in this country creates an extremely serious threat to the low-income children and their families, and there is an absolute immediate need to enact reforms that address uninsuredness among children and to make a preventive investment in our Nation's children. Medical indigency also poses a substantial threat to the health care system that cares for low-income families. Many public and community clinics and institutions that are treating the poor are under serious financial stress.

Thus, we believe that the remedy should include two basic approaches, neither of which is exclusive. First, we need to improve private and public health insurance programs in order to generate a health care financing system that insures individuals for basic services. In the case of children and pregnant women, the cost of those insurance reforms are relatively modest, particularly in comparison to the long-term costs associated with failure to make such reforms. Secondly, we must provide ample support to public and community institutions that provide a large volume of care to the uninsured.

I would like to conclude by summarizing briefly our specific recommendations to Congress. One, Congress and the States must act to further reduce uninsuredness among poor pregnant women and poor and near-poor children. New Federal mandates for Medicaid are the stepping stone for this reform, including Medicaid coverage to all pregnant women and infants with incomes below 200 percent of the Federal poverty level, at a cost of $120 million over the next 3 years; the second being Medicaid coverage to all poor children at a cost of $200 million over the next 3 years. We also recommend phasing in coverage of near-poor children over the years.

My written testimony includes specific funding proposals for providing support and financial resources to the infrastructure of services for low-income women and children, and I refer you to that testimony for that information.

[The statement of Ms. Hughes follows:]

STATEMENT OF DANA HUGHES, ASSISTANT DIRECTOR FOR STATE AND LOCAL AFFAIRS, CHILDREN'S DEFENSE FUND

Mr. Chairman and Members of the Committee:

The Children's Defense Fund (CDF) is pleased to have this opportunity to testify today regarding health insurance and the uninsured. CDF is a national public charity which engages in research and advocacy on behalf of the nation's low income and minority children. For more than fifteen years, CDF's health staff has made efforts to improve the health of poor children in this country by ensuring their access to medically necessary care.

I want to both thank and commend the committee for holding this hearing today to focus on attention on one of the major threats to the health of children and their families: lack of adequate health insurance. Ample data show that access to health care in this country is determined in large part by whether a person has health insurance and whether that policy covers the needed treatment or care. Without adequate coverage, the nation's 11 million children who have no health insurance are at risk of disabling and life-threatening conditions, the majority of which can be managed, if not altogether prevented, through appropriate health care. As the number of Americans without adequate health insurance climbs, the proportions of this threat multiply, risking the health and well-being of our children as well as our nation's future. Thanks to your leadership, Mr. Chairman, and that of others, the significance of the uninsuredness crisis is better understood today and consequently, the nation is more willing to grapple with it. This hearing today will move the national debate closer to meaningful reform.

My testimony today will be divided into four sections: The Insurance Status of Children; The Significance of Inadequate Health Insurance for Health; What Can be Done; and Recommendations.

The Insurance Status of Children

Of the 37 million Americans who are uninsured, approximately one-third -- over 11 million -- are children. In 1986, nearly one out of five children living in families (which excludes such children as those living in institutions) was completely uninsured (Table 1). Uninsuredness among children is not only disturbingly high, but on the rise. Between 1980 and 1985, the proportion of children under age 18 covered by employer insurance fell by 6 percent (from 64.6 percent to 60.6 percent. Among poor children under age 18, the proportion privately covered declined by one-quarter, from 16.9 percent to 12.8 percent. [1]

However, as shocking as these facts are, they mask key differences by family income, race, parents' employment status, and source of health insurance coverage, variations that have critical implications for the design of interventions to reduce the proportion of uninsured children and improve children's health status.

Family Income, Employment, and Health Insurance Status: Data from the U.S. Census Bureau and calculated by CDF indicate that children in more affluent families are more likely to be insured.[2] As the income of families with children rises, the proportion of completely uninsured children declines. However, a considerable proportion of children from even moderate-income households are completely uninsured. In 1986, when 18.0 percent of all children living in families were uninsured, 32.4 percent of children living in families with incomes less than the federal poverty level were uninsured. Even among children living in families with incomes between 100 and 200 percent of the federal poverty level, 28.7 percent were completely uninsured.

Children in working families are even more likely than those in non-working families to be completely uninsured, especially when they live in low- and moderate-income families (Table 2). In 1986, 19.1 percent of children in working families and 42 percent of poor children in such families, were completely uninsured. This phenomenon results from at least two factors. First, the employer-based health insurance coverage system has eroded over the past decade, leaving more and more children without private health insurance. Second, children living in working households, particularly those in moderate-income households, are generally ineligible for Medicaid coverage.

Working families with children, even when poor, always have faced barriers to Medicaid eligibility. Many of these families are disqualified because their earnings, while very low, exceed state's Medicaid financial eligibility level (Table 3).

Furthermore, Medicaid historically has been restricted to children living in single-parent families. Other children living in low-income working families were disqualified because of the presence of both parents in the household. While states today have the option to provide Medicaid to children in two-parent working families, sixteen states still have not elected to exercise this option.

Employer-subsidized health insurance is the primary source of health care financing for Americans younger than sixty-five. But children living in working families may lack coverage because the parent's employer does not offer insurance coverage at all or because family coverage is made available only at unaffordable rates. Lower-paid jobs are less likely to provide any insurance; even when insurance theoretically is available, employers of lower-paid workers are less likely to pay all or most of the premiums for dependent coverage. In 1986 fewer than two out of five children with employer coverage lived in families that reported that the employer or union paid all premium costs.

Family income is a determinant not only of whether a child has employer coverage at all, but also of whether the employer plan pays all of the cost of the family's insurance premium. In 1986, 38.2 percent of all employer-insured children in working households were covered by a plan that reportedly paid all of the cost of coverage. However, only 27.3 percent of children in poor working household had such coverage. Employer subsidization of the cost of a family's plan this is most commonly available for the families that need the subsidy the least.

Employer subsidization of the cost of family coverage has been declining during the 1980s. Between 1980 and 1986, the proportion of medium-size and large firms (those most likely to offer coverage at all) paying the full cost of the the annual premium for family health coverage declined to 35 percent, a nearly one-third drop below the 1981 level of 51 percent. [3] This change in employer-dependent subsidy practices, combined with the growing number of older children who still may be living with their families but who nonetheless can no longer be considered "dependents" under their parents' insurance plans, swelled the ranks of the uninsured children. The U.S. Congressional Research Services recently reported that virtually all of the growth in the number of uninsured American's since 1980 is the result of declining employer-based coverage of dependents. [4]

Federal and state reforms since 1986 have liberalized Medicaid eligibility criteria for infants and preschool children somewhat. However, these expansions completely exclude poor children older than eight whose family incomes are above state AFDC levels, and all near-poor children older than one, even though children living in families with incomes between 100 and 200 percent of the federal poverty level are nearly as likely as poor children to be uninsured.

The absence of health insurance, public or private, therefore, is seen most clearly among children in low-income working families. These children are less likely to have access to employer-based family coverage than other children in working families, and yet are unlikely to be eligible for Medicaid. In 1986, 66.9 percent of all children living in working families had employer coverage. However, only 17.6 percent of poor children in working families, and only 41.3 percent of children in working families with incomes less than 200 percent of the federal poverty level, had employer coverage. Despite the low rates of employer coverage, only 36.2 percent of children living in poor working families, and only 19.6 percent of children in working families with incomes less than 200 percent of the federal poverty level, had Medicaid coverage.

Race and Health Insurance: Regardless of family income or employment status, black children are less likely than white children to have employer coverage (Tables 1 and 2). As a result, black children in working families are more likely than white children to be completely uninsured, regardless of family income (Figures 1 and 2).

In 1985 black children, who were far more likely to live in poor families. were more than three times as likely as white children to have Medicaid coverage (31.4 percent versus 9.9 percent). They were only about 60 percent as likely to have employer-based coverage, however (39.0 percent versus 65.9 percent).

When only children in working households are considered, however, the proportion of black children with Medicaid coverage in 1986 dropped by nearly one-half, from 31.4 percent to 18.0 percent. The proportion of black children with employer-based coverage rose by only a little more than one-quarter, from 39.0 percent to 49.3 percent of all black children. As a result, three out of ten black children in employed families were wholly uninsured in 1986.

Racial disparities in insurance coverage were most notable among children living in working families. While 29.3 percent of black children in employed families were completely uninsured in 1986, only 17.5 percent of white children were uninsured. Similarly, while 69.8 percent of white children in employed families had employer coverage, only 49.3 percent of black children had employer coverage.

The probable cause of this disparity in insurance status is that black children living in working families are more likely to fall into a given income range because they have two parents working at relatively low-wage jobs as opposed to one parent working for higher wages. Low-wage jobs are less likely to include family insurance coverage, or coverage with employer-paid premiums.

Insurance Coverage of Women of Childbearing Age: Insurance coverage for women of childbearing age is a serious problem as well. According to the Alan Guttmacher Institute, in 1985, 9.5 million women ages fifteen to fourty-four had no health insurance, public or private. [5] This was 17 percent of all women of that age group. If women with private insurance that fails to include coverage for maternity care were included, more than 14 million women (or 25 percent) were completely unprotected against the cost of maternity care in 1985. Among all women of childbearing age, those most likely to be uninsured were either unemployed or working at low-wage jobs (Figure 3). As with black children, black women were more likely to be completely uninsured than their white counterparts.

Private health insurance is the primary source of coverage in this country, but large proportions of poor women are without private insurance. In 1985, 35 percent of all women ages 15 to fourty-four with income less than 100 percent of th poverty level had no private health insurance, compared with 11 percent of women with incomes at or more than 200 percent of the poverty level.

Insurance Status, Health Care Utilization and Health Status

Numerous studies show that health insurance is a significant determinant of health care utilization. The uninsured use substantially fewer services than their insured counterparts, even when health status and the need for services is taken into account.[6] Research also has shown that even among the poorest families, health care coverage can bring health care utilization up to average levels. [7]

- National survey data reveal that low-income uninsured children have a lower likelihood of, and a significantly lower average of, visits to physicians. When adjusted for health status, uninsured children remain most likely to have no physician visits in a year. [8]

- Even among children with identified disabilities who participate in special education programs, lack of health insurance has been found to be associated with reduced access to necessary health care. [9]

- However, poor children with Medicaid coverage are far more likely than uninsured poor children to have a regular source of health care and to visit a physician in a year. Medicaid recipient children use services in a pattern similar to that of their affluent, privately insured counterparts. [10]

- Uninsured low income women are less likely to receive care early in pregnancy and are twice as likely to receive late or no prenatal care. [11]

Adequate access to health care is critical to maternal and child health and saves money by preventing unnecessary illness, disability, and death.

Maternity care, beginning with prenatal care in the critical first three months of pregnancy and continuing through the birth of a child, can dramatically improve maternal and infant health. An infant born to a women receiving no prenatal care is more than 3 times more likely to die in the first year of life. Prenatal care can save more than $3 for every $1 invested. [12] Yet each year, millions of infants are born to women who did not receive early care.

In 1986, a smaller percentage of mothers received early prenatal care than in 1980. The percentage of mothers who received late or no prenatal care increased in 1986, the seventh year in a row of no improvement or worsening. Among black mothers, the late and no prenatal care figure increased in 1986 for the fifth time since 1980.[13]

Immunizations, which should begin in the first months of life, can eliminate the death and disability that can result from now-preventable, childhood diseases such as measles, mumps, pertussis (whooping cough), diphtheria, tetanus, polio, and meningitis. Childhood immunizations save $10 for every $1 invested. However, between 1980 and 1985, immunization levels for our nation's infants and toddlers eroded significantly (Table 4). [14]

Inadequate immunization levels lead to outbreaks of preventable disease. Nationwide in 1987, there were over 2,800 reported cases of pertussis, with nearly half occurring among infants. In that year, there were over 1,000 cases of measles and over 800 cases of mumps among preschool age children (younger than age 5).[15]

Comprehensive primary and preventive care for children can detect and treat a wide range of health conditions before they become serious. Screening for lead poisoning, learning disabilities, vision impairments, and dental health needs can reduce the consequences of these health problems. Children who receive comprehensive primary health care have annual health costs 7 to 10 percent lower than those who do not.

Despite this evidence, many children do not receive such preventive care. In 1986, as a result of inadequate access to health care, poor children were considerably more likely than affluent children to have had a routine physical in the previous year.[16]

- National surveys indicate that poor children are at least 3 times more likely than affluent children to have never had a physician visit (5.4 percent and 1.6 percent, respectively).[17]

What Can be Done

We understand how to keep most children healthy. We know that every child needs health care. Good medical care begins before a child's birth with comprehensive prenatal care. It continues throughout childhood, with care for a child's preventive, acute, and chronic health care needs.

No child--whether the need is for immunization, treatment for a strep throat, dental care, hospitalization, medicines, or eyeglasses--should go without health care because a family cannot afford it. No pregnant woman should be denied prenatal care because she does not have enough money to pay for it.

The current gaps in insurance coverage and medical care among children are costly in both human and fiscal terms. Maternity and pediatric services have been found not only to be effective but also to be a remarkably cost-effective type of health care investment. Our highly sophisticated medical system can offer preventive or remedial care for most child health problems. Yet a series of events have left our children vulnerable to preventable childhood disease, disability, and death.

Medical indigency not only creates an extremely serious threat to the health of low income children and families, but it also poses a substantial threat to the health care system that cares for low income families. Many public and community clinics and institutions treating the poor are under serious financial stress, chiefly because of the combined effects of the large size of the medically indigent population they treat and shortfalls in rates paid by various public and private payers for their insured patients.

Thus, there are two basic approaches to dealing with the problem. Neither is exclusive. First, we need to improve public and private health insurance programs in order to generate a health care financing system that insures individuals for basic services. In the case of children and pregnant women, the cost of insurance reforms are relatively modest in comparison to the longterm costs associated with failure to make such reforms.

Second, direct subsidies to public and community institutions providing a large volume of care for the uninsured are needed.

Recent Improvements in Maternal and Child Health Programs: In recent years, Congress has taken steps to improve access to health care for pregnant women, infants, and children. These include changes in key maternal and child health programs such as Medicaid, the Maternal and Child Health Block Grant, Community and Migrant Health Centers, childhood immunization, and health manpower programs.

Medicaid: The Medicaid program is the primary health care financing program for low income children and pregnant women. In 1987, more that 11.6 million children under age 18 received services paid for by Medicaid. Medicaid paid for maternity care for approximately one-half million births that year.

Since 1984, in an effort to improve maternal and child health among low income families, Congress has enacted a series of Medicaid improvements. (Figure 4) As a result, by 1990 all pregnant women and infants with family incomes below 100 percent of the federal poverty level ($9690 per year for a family of three in 1988) will be covered by Medicaid in all states, and several states will have extended coverage to pregnant women and infants with family incomes below 185 percent of the federal poverty level (roughly $18,000 per year for a family of three).

In addition, 30 states have used the option to extend coverage to some of the youngest children with family incomes below the poverty level. However, millions of poor children nationwide remain uncovered.

If all states extended coverage to pregnant women and infants with family incomes below 185 percent of the federal poverty level (nine already do so), then Medicaid will be available to cover health care costs for nearly one out of two births in the United States. If coverage were extended to all children with family incomes below the federal poverty level, Medicaid would become a source of health care financing for one in five American children.[18] A substantial proportion of these families currently have no source of health care coverage, public or private.

Title V Maternal and Child Health Block Grant: For over fifty years, the Title V Maternal and Child Health programs have served our nation's mothers and children. Title V programs provide prenatal care to hundreds of thousands of low income and medically indigent pregnant women. Millions of children receive basic preventive health care and treatment for minor illnesses, as well as specialized health services for chronic illnesses and disabilities.

Since Fiscal Year 1987, a portion of any newly appropriated funds have been earmarked for child health demonstration projects.

Community and Migrant Health Centers: The nearly 600 community and migrant health centers are comprehensive primary health clinics funded by the federal government and located in some of the most medically underserved communities in the United States. Health Centers serve nearly 6 million low income patients annually. In 1986, more than one-third of patients were children under age 14 and one in four was a woman of childbearing age. About 10 percent of all low income births nationally were to health center patients that year.

For Fiscal Years 1988 and 1989, Congress added a funding supplement to the health centers programs for infant mortality reduction services. (Basic funding levels are set at $415 million for community health centers and $45 million for migrant

health centers.) The current $20 million funding level for this supplement is adequate to fund only a little over one-third of existing health centers, and even these clinics have received only about half of the amount that they needed to expand and strengthen their service capacity.

Childhood Immunization The federal childhood immunization program is the main source of public support for the nation's efforts to reduce preventable childhood disease. Through the program, grants are provided to allow state and local health agencies to purchase vaccines for millions of American children. The program also provides basic funding for the infrastructure of our national vaccine system (e.g., storage and preservation of vaccines in an emergency stockpile, centralized surveillance, and outbreak control activities).

For Fiscal Year 1989, Congress appropriated an additional $40 million for the vaccine program activities. However, following a decade of spiraling vaccine price inflation and eroding childhood immunization levels, additional funds are needed to bolster this critical system.

Health Manpower Programs: A health manpower crisis for poor and rural communities looms on the horizon. In 1981, Congress, at the urging of the Reagan administration, began a phase-out of the National Health Service Corps scholarship program. By 1988 only 40 scholarships were awarded, compared to over 4,300 in 1980. As fewer scholarships are awarded, the service pipeline in-turn will run dry.

The health manpower programs which were reauthorized by Congress in 1988 to provide scholarship and loan assistance to medical, nursing and health professions students and graduates will make a small dent in this problem. However, the nation now has over 1,900 primary care health manpower shortage areas, affecting nearly 13 million people.

Recommendations

If the nation is to make real progress in reducing infant and childhood death and disability, then the reform efforts undertaken since the mid-1980's must be expanded and strengthened. The following expenditures represent a basic level of investment in the health of America's children.

1. Congress and the states must act to further reduce uninsuredness among near-poor pregnant women and poor and near-poor children. New federal mandates for Medicaid coverage of these groups should be phased-in over the next few years.

- Medicaid coverage should be provided to all pregnant women and infants with family income below 200 percent of the federal poverty level. Federal outlays of approximately $120 million over the next three years would be needed to begin the phase-in.

- The Medicaid programs should be expanded to cover all poor children. The federal share of this expansion would be approximately $200 million over the next three years. Coverage for near-poor children should be phased-in in future years.

- In addition, states should be given the authority now to improve their Medicaid programs in a number of ways. For example, policies which allow states to guarantee annual enrollment periods for children, eliminate resource tests, and conduct aggressive outreach programs are important steps in ensuring that Medicaid-eligible children and pregnant women enroll in the program early and receive the preventive and primary health care they need. These are low cost

initiatives which make federal and states eligibility expansions meaningful at the local community level.

2. Congress should expand access to care through enhancements to publicly-funded health programs.

- Funding for the Community and Migrant Health Centers should be expanded so that clinics can be developed in all medically underserved areas and maternity and infant services can be expanded and strengthened in all clinics. An additional $47 million is needed in Fiscal Year 1990 to adequately fund the health centers' the maternity and infant care initia ve.

- The Title V Maternal and Child Health Block Grant should be expanded to permit states to better develop comprehensive maternal and child health services in underserved areas. An investment of an additional $100 million would permit nearly all states to develop statewide networks of providers.

- Funding levels for the childhood immunization program must remain adequate to ensure purchase of the necessary level of public sector vaccine, a system for providing families with information about the availability and safety of vaccines, and generally to support a national childhood vaccine system. An additional $35 million is needed in Fiscal Year 1990 to protect all of our children against preventable childhood disease.

- Health manpower programs which designed to provide scholarship and loan assistance to medical, nursing, and health professions students and graduates working in manpower shortage areas should be fully funded in Fiscal 1990. Full funding for these programs would cost approximately $162 million.

The question is not whether the nation can afford these reforms but whether the nation can afford not to enact them. Our recommendations have a Fiscal Year 1990 price tag of less than $700 million. The first year costs alone of caring for infants born too soon and too small whose condition could have been prevented if the nation had made sufficient progress to meet the Surgeon Generals 1990 Health Objective will exceed $6 billion by the year 2000. The cost of the reforms CDF recommends is very small compared to the cost of lifetimes of treatment and lost earnings for children whose disabilities could have been prevented. These expenditures represent such a basic level of investment in the health and safety of all of our children that their enactment cannot be further delayed.

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Table 1

Insurance Status of Children Younger than 18 in Families, by Income[1], Race, and Insurance Status, U.S., 1986

Income as a percent of poverty	All Races			White			Black		
	Less Than 100%	Less Than 200%	All	Less Than 100%	Less Than 200%	All	Less Than 100%	Less Than 200%	All
Children in Families (in thousands)	12,715	26,355	62,745	8,070	18,836	50,934	4,129	6,560	9,606
Percentage of insured children by type of coverage[2]									
Medicaid alone or with other coverage	52.3%	30.3%	13.4%	47.2%	25.2%	9.9%	61.6%	43.8%	31.4%
Medicaid only	48.3%	26.8%	11.7%	42.9%	21.7%	8.4%	59.0%	40.7%	28.7%
Employer coverage	11.5%	33.6%	61.4%	13.4%	37.3%	65.9%	7.9%	23.6%	39.0%
VA, CHAMPUS, military[3]	2.2%	3.8%	3.9%	2.7%	4.3%	3.8%	—	1.4%	4.1%
Other health insurance	0.0%	7.1%	7.6%	7.7%	8.2%	8.2%	—	2.9%	4.4%
Percentage of children insured	67.6%	69.6%	81.1%	66.3%	69.6%	82.5%	69.9%	69.1%	73.6%
Percentage of children uninsured	32.4%	30.4%	18.9%	33.7%	30.4%	17.5%	30.1%	30.9%	26.4%

[1]Income measured as a percentage of the federal poverty level

[2]Percentages may not equal 100 percent because some children have insurance from more than one source

[3]The U.S. Department of Defense covers health care for members of the military and their dependents, including children, at military institutions and at civilian facilities

SOURCE: Unpublished data from the U.S. Bureau of the Census. Calculations by Children's Defense Fund

Table 2

Percentage of Children in Families with Employer-Based Coverage with All Premiums Paid by Employer or Union, by Income[1], Age, and Race, U.S., 1986

	Total Number of Children With Employer-Based Coverage (in thousands)				Percentage of Children with All coverage Costs Paid by Employer or Union			
Income Level	Less Than 100%	Less Than 200%	Less Than 400%	All	Less Than 100%	Less Than 200%	Less Than 400%	All
All races								
Under age 6	593	3,345	9,571	13,125	28.2%	31.0%	34.8%	37.9%
Ages 6-17	863	5,503	17,610	25,415	20.8%	31.8%	36.1%	38.4%
Total	1,456	8,848	27,181	38,540	27.3%	31.5%	35.7%	38.2%
White								
Under age 6	408	2,773	8,330	11,533	29.7%	31.9%	35.9%	38.8%
Ages 6-17	611	4,256	14,925	22,018	33.4%	35.0%	37.7%	39.7%
Total	1,079	7,029	23,255	33,551	31.8%	33.8%	37.0%	39.4%
Black								
Under age 6	106	479	990	1,177	—	25.5%	26.3%	27.8%
Ages 6-17	221	1,067	2,166	2,567	—	20.2%	26.0%	27.6%
Total	327	1,546	3,156	3,744	—	21.9%	26.1%	27.6%

[1]Income measured as a percentage of the federal poverty level

SOURCE: Unpublished data from the U.S. Bureau of the Census. Calculations by Children's Defense Fund

Table 3

State Medicaid Eligiblity Levels for Children and Pregnant Women, October 1988

State	Maximum Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for a Family of Three				
	Pregnant Women and Infants	Young Children[1]	Older Children	Medically Needy Income Level	Maximum AFDC Payment Level[2]
Alabama	100.0	14.6	14.6	—	14.6
Alaska	100.0	77.2	77.2	—	77.2
Arizona	100.0	100.0(5)	36.3	—	36.3
Arkansas	100.0	100.0(5)	25.3	34.1	25.3
California	185.0	82.1	82.1	110.5	82.1
Colorado	52.1	52.1	52.1	—	44.1(52.1)
Connecticut	185.0	77.2	77.2	87.9	77.2
Delaware	100.0	39.5	39.5	—	39.5
District of Columbia	100.0	100.0(2)	46.9	60.1	46.9
Florida	100.0	100.0(8)	34.1	45.4	34.1
Georgia	100.0	100.0(5)	33.4	45.4	33.4
Hawaii	100.0	59.9	59.9	59.9	59.9
Idaho	68.0	37.6	37.6	—	37.6
Illinois	100.0	42.4	42.4	56.7	42.4
Indiana	50.0	35.7	35.7	—	35.7
Iowa	150.0	100.0(5)	48.8	65.0	48.8
Kansas	100.0	100.0(2)	52.9	59.4	52.9
Kentucky	125.0	100.0(2)	27.0	36.2	27.0
Louisiana	100.0	100.0(8)	23.5	32.0	23.5
Maine	185.0	100.0(5)	71.0	69.1	51.5(71.0)
Maryland	100.0	100.0(2)	46.7	54.7	46.7
Massachusetts	185.0	100.0(5)	66.7	90.8	66.7
Michigan	185.0	100.0(5)	74.8	68.0	57.7(74.8)
Minnesota	185.0	65.9	65.9	87.8	65.9
Mississippi	185.0	100.0(5)	45.6	—	14.9(45.6)
Missouri	100.0	100.0(5)	34.9	—	34.9
Montana	50.5	44.5	44.5	50.5	44.5
Nebraska	100.0	100.0(5)	45.1	60.9	45.1
Nevada	40.9	40.9	40.9	—	40.9
New Hampshire	69.0	61.4	61.4	69.0	61.4
New Jersey	100.0	100.0(2)	52.5	70.1	52.5
New Mexico	100.0	100.0(5)	32.7	—	32.7
New York	82.4	82.4	82.4	78.5	82.4
North Carolina	100.0	100.0(5)	32.9	44.3	32.9
North Dakota	53.9	45.9	45.9	53.9	45.9
Ohio	100.0	38.3	38.3	—	38.3
Oklahoma	100.0	100.0(2)	58.3	53.6	38.4(58.3)
Oregon	100.0	100.0(3)	51.0	69.2	51.0
Pennsylvania	100.0	100.0(5)	49.8	55.7	49.8
Rhode Island	185.0	100.0(8)	64.0	85.7	64.0
South Carolina	100.0	49.9	49.9	—	24.9(49.9)
South Dakota	100.0	45.3	45.3	—	45.3
Tennessee	100.0	100.0(5)	45.2	28.9	21.4(45.2)
Texas	100.0	100.0(5)	22.8	33.1	22.8
Utah	100.0	62.2	62.2	62.0	46.6(62.2)
Vermont	185.0	100.0(8)	77.9	104.1	77.9
Virginia	100.0	43.8	43.8	44.3	43.8
Washington	90.0	90.0(3)	60.9	74.2	60.9
West Virginia	150.0	100.0(8)	30.8	35.9	30.8
Wisconsin	120.0[3]	64.0	64.0	85.3	64.0
Wyoming	100.0	44.6	44.6	—	44.6

[1]States have the option of covering children older than one born after September 30, 1983, with incomes above the AFDC payment level and up to the federal poverty level until their eighth birthday. The number in parentheses indicates the age limit chosen by states for eventual coverage if more than the current age limit.

[2]Most states use the AFDC payment level as the Medicaid income eligibility threshhold. Eight states have chosen to use the higher AFDC standard of need level to determine Medicaid eligibility. The AFDC standard of need level is included in parentheses for those states.

[3]100 percent state-funded.

Table 3 (con't)

State Medicaid Eligibility Characterists for Children and Pregnant Women
October 1988

State	Expanded Financial Eligibility			Current Maximum Age for Children Under 100% Poverty[1]	Other Eligibility and Benefit Options		
	Up to 100% of Federal Poverty Level		Above 100% of Federal Poverty Level				
	Pregnant Women and Infants	Children Over Age One	Pregnant Women and Infants		Waives Asset Test	Continuous Eligibility for Pregnant Women	Presumptive Eligibility
Alabama	Yes	No	No	—	Yes	Yes	Yes
Alaska	Yes	No	No	—	No	No	No
Arizona	Yes	Yes	No	5	Yes	Yes	No
Arkansas	Yes	Yes	No	5	No	Yes	Yes
California	Yes	No	Yes	—	No	No	No
Colorado	No	No	No	—	No	No	No
Connecticut	Yes	No	Yes	—	Yes	Yes	No
Delaware	Yes	No	No	—	Yes	Yes	No
District of Columbia	Yes	Yes	No	2	Yes	Yes	No
Florida	Yes	Yes	No	5	Yes	Yes	Yes
Georgia	Yes	Yes	No	2(5)	Yes	No	Yes
Hawaii	Yes	No	No	—	Yes	Yes	Yes
Idaho	Yes	No	No	—	Yes	No	No
Illinois	Yes	No	No	—	Yes	Yes	Yes
Indiana	Yes	No	No	—	Yes	Yes	Yes
Iowa	Yes	Yes	Yes	2(5)	No	No	No
Kansas	Yes	Yes	No	2	Yes	No	No
Kentucky	Yes	Yes	Yes	2	No	Yes	No
Louisiana	Yes	Yes	No	5(8)	Yes	Yes	Yes
Maine	Yes	Yes	Yes	5	Yes	Yes	Yes
Maryland	Yes	Yes	No	2	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	5	Yes	Yes	Yes
Michigan	Yes	Yes	Yes	3(5)	Yes	Yes	No
Minnesota	Yes	No	Yes	—	Yes	Yes	No
Mississippi	Yes	Yes	Yes	2(5)	No	Yes	No
Missouri	Yes	Yes	No	3(5)	No	Yes	No
Montana	No	No	No	—	No	No	No
Nebraska	Yes	Yes	No	2(5)	Yes	Yes	Yes
Nevada	No	No	No	—	No	No	No
New Hampshire	No	No	No	—	No	No	No
New Jersey	Yes	Yes	No	2	Yes	Yes	Yes
New Mexico	Yes	Yes	No	3(5)	No	Yes	Yes
New York	No	No	No	—	No	No	No
North Carolina	Yes	Yes	No	3(5)	Yes	Yes	Yes
North Dakota	No	No	No	—	No	No	No
Ohio	Yes	No	No	—	Yes	Yes	No
Oklahoma	Yes	Yes	No	2	Yes	Yes	No
Oregon	Yes	Yes	No	3	Yes	Yes	No
Pennsylvania	Yes	Yes	No	3(5)	Yes	No	Yes
Rhode Island	Yes	Yes	Yes	5(8)	Yes	Yes	No
South Carolina	Yes	No	No	—	Yes	Yes	No
South Dakota	Yes	No	No	—	Yes	Yes	No
Tennessee	Yes	Yes	No	5	Yes	Yes	Yes
Texas	Yes	Yes	No	2(5)	No	Yes	Yes
Utah	Yes	No	No	—	Yes	Yes	Yes
Vermont	Yes	Yes	Yes	5(8)	No	Yes	No
Virginia	Yes	No	No	—	Yes	Yes	No
Washington	Yes	Yes	No	3	No	Yes	No
West Virginia	Yes	Yes	Yes	5(8)	Yes	Yes	No
Wisconsin	Yes[2]	No	Yes[2]	—	No	No	Yes
Wyoming	Yes	No	No	—	Yes	Yes	No
Total	45	28	13		33	37	20

[1]Number in parentheses indicates authorized age limit in states phasing in coverage of children below poverty.

Notes on Table 3

Medicaid eligibility determination is a complex process involving "mandatory" and "optional" financial requirements and "categorical" groupings. Furthermore, because Medicaid is a joint federal and state program that provides the states with an array of options to decide who can qualify for Medicaid, there are vast differences between state Medicaid programs.

States are required to cover the "categorically needy." The categorically needy include all (with very minor exceptions) AFDC and Supplemental Security Income recipients and pregnant women who would qualify for AFDC if the child was already born. Beginning in 1990, all infants and pregnant women with family incomes less than the federal poverty level and above the AFDC payment level also will be considered mandatorily categorically needy and all states must extend Medicaid benefits to them.

States also may elect to cover the "medically needy." The medically needy include those who fall into one of the Medicaid program's permissible coverage categories (including children, pregnant women, caretaker relatives, and aged and disabled individuals) but whose incomes or assets are too high to qualify for Medicaid outright. The medically needy can qualify for Medicaid by incurring medical bills that cause them to "spend down" their incomes to the state's medically needy income eligibility level. If a state decides to cover any group of the medically needy, it must cover medically needy children and pregnant women.

Medicaid's close ties to low AFDC income and asset limits and AFDC's various family structure requirements traditionally have limited eligibility to the very poorest children and often only those in single-parent families. Until recently, very poor children with incomes below AFDC program levels but not "dependent" within the meaning of AFDC could be excluded from Medicaid coverage. By October 1989, coverage of these children younger than seven is mandatory. However, states may still exclude children after their seventh birthday with such very low incomes.

Recent Medicaid expansions provide the states with options to simplify and loosen the eligibility requirements for pregnant women and children. The states now can choose to:

- Cover all pregnant women and infants younger than one year old with family incomes up to 185 percent of the federal poverty level. States can choose any income standard above the AFDC payment level. However, by 1990 states must cover all infants and pregnant women below the federal poverty level.
- Phase in coverage annually of all children older than one born after September 30, 1983, with incomes less than the federal poverty level with coverage ceasing at their eighth birthday. States can choose an income level between the AFDC payment standard and the poverty line and can set an age cutoff of between two and eight years old.
- Waive application of any asset test in the case of pregnant women and infants and young children.
- Provide continuous coverage to pregnant women throughout their pregnancies and sixty days post partum, regardless of any changes in income.
- Provide presumptive eligibility to pregnant women (that is, provide temporary Medicaid coverage immediately) while their formal applications are considered.

Table 3.2 details each state's Medicaid program and its response to the new options to provide coverage for more pregnant women and children. Positive responses have been recorded if a state has enacted enabling legislation and also has a fixed effective date.

Notes on Table 3 (con't.)

Expanded Financial Eligibility

Pregnant Women and Infants Up to 100 Percent of the Federal Poverty Level: This column depicts states that have expanded eligibility to all pregnant women and infants below the federal poverty level (and thus have removed all non-financial eligibility requirements). Forty-four states and the District of Columbia have elected to cover some portion of poor pregnant women with incomes above the AFDC payment level. Only Colorado, Montana, Nevada, New Hampshire, New York, and North Dakota have not yet expanded coverage for infants and pregnant women. Of the states that have chosen to expand coverage, only Idaho, Indiana, and Washington have not included all women and infants with incomes below 100 percent of poverty. By 1990 states will be required to cover all pregnant women and infants below the federal poverty level.

Children Older than One Up to 100 Percent of the Federal Poverty Level: Thirty states now cover young poor children with family incomes below the federal poverty level. All of these states, except for Washington, have chosen to include all children with family incomes below the federal poverty level. Washington state has set its standard for these children at 90 percent of the poverty line. The current maximum age limits for these children also are included in this table. The phase-in age limits authorized by each state are included in parentheses. Only Arkansas, Florida, Louisiana, Rhode Island, Vermont, and West Virginia have passed legislation to phase in coverage up to a child's eighth birthday.

Pregnant Women and Infants Above 100 Percent of the Federal Poverty Level: Thirteen states have elected to cover near-poor women and infants. Nine of the thirteen chose to cover all near-poor women and infants with incomes below 185 percent of the federal poverty level.

Other Eligibility and Benefit Options

Waives Asset Test: Thirty-three states have waived the asset test for pregnant women and children younger than five. It is important to note that virtually all of the remaining states, while not waiving the asset test entirely, have broadened and simplified it considerably. Many have eliminated consideration of assets such as homes, cars, and income-producing property.

Continuous Eligibility: Thirty-seven states have guaranteed continuous Medicaid eligibility for pregnant women.

Presumptive Eligibility: Twenty states have presumptive eligibility either on a statewide basis or in certain communities. Most of these states are conducting pilot programs and are not offering presumptive eligibility as a statewide policy.

Table 3.3 lists the highest Medicaid eligibility levels available for pregnant women, infants, young children, and older children as a percent of poverty. Young children are those older than one with family incomes between the AFDC payment standard and the federal poverty level who could be covered at the option of a state. The authorized phase-in age limits chosen by states electing this option are included in parentheses. In addition, the table includes each state's maximum AFDC payment level for a family of three with no income. Most states use the AFDC payment level as the Medicaid income eligibility threshold. However, eight states have chosen to use the higher AFDC standard of need level to determine Medicaid eligibility. The AFDC standard of need level is included in parentheses for those states. For states with medically needy programs, the medically needy income level also is included.

Table 4

Percentage of Infants and Toddlers Who Were Fully Immunized[1], by Age and Race, U.S.[2], 1980 and 1985

Infants						
		Polio	**DTP[3]**	**Measles**	**Mumps**	**Rubella**
Total	1980	80.0	84.2			
	1985	79.6	82.7	These vaccines are not recommended for children of this age.		
White	1980	80.9	84.9			
	1985	81.5	84.4			
Nonwhite	1980	73.2	79.0			
	1985	58.5	64.8			
Age one						
		Polio	**DTP**	**Measles**	**Mumps**	**Rubella**
Total	1980	95.5	76.2			
	1985	95.2	78.3	These vaccines are not recommended for children of this age.		
White	1980	96.2	78.6			
	1985	96.9	80.1			
Nonwhite	1980	89.1	56.5			
	1985	82.3	64.9			
Age two						
		Polio	**DTP**	**Measles**	**Rubella**	**Mumps**
Total	1980	80.7	87.0	83.0	83.2	80.2
	1985	76.7	85.8	81.7	77.3	78.9
White	1980	83.0	89.4	84.8	84.4	81.5
	1985	79.5	88.0	82.7	78.6	80.8
Nonwhite	1980	62.8	68.0	69.0	73.4	70.7
	1985	56.5	69.1	74.7	66.9	64.2

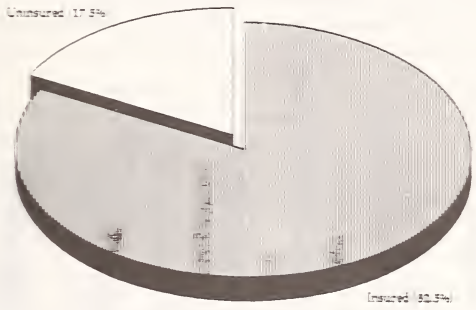
[1]Dosage levels are approximations of levels needed to fully immunize a child of a given age: younger than age one, one or more doses of polio and DTP; at age one, one or more doses of polio and three or more doses of DTP; and at age two, three or more doses of polio and DTP and one dose of measles, rubella, and mumps vaccines.

[2]Data are from the U.S. Immunization Survey sample confirmed by parent consultation with an immunization record.

[3]DTP stands for a combined dose of diphtheria, tetanus, and pertussis vaccines.

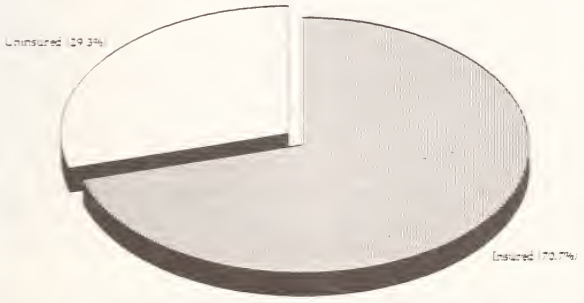
SOURCE: U.S. Immunization Survey, Centers for Disease Control.

Figure 1
White Children in Employed Families, by Insurance Status, 1986



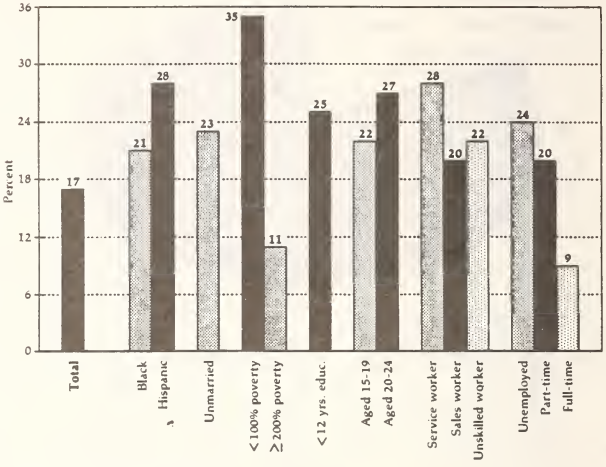
SOURCE: U.S. Bureau of the Census.

Figure 2
Black Children in Employed Families, by Insurance Status, 1986



SOURCE: U.S. Bureau of the Census.

Figure 3
Percent of Women Ages 15-44 Without Private Health Insurance, by Selected Characteristics, 1985



SOURCE: Alan Guttmacher Institute.

Chairman STARK. Thank you very much.
Mr. Barch.

STATEMENT OF MICHAEL M. BARCH, VICE CHAIRMAN, TASK FORCE FOR THE CARE OF THE MEDICALLY INDIGENT, DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION, ACCOMPANIED BY JOHN BILLINGS, J.D., INDEPENDENT CONSULTANT

Mr. BARCH. Good morning, Mr. Chairman and members of the committee. My name is Michael Barch, and I am the director of administrative affairs at the George Washington University Medical Center here in the District of Columbia. I am also the cochairman of the District of Columbia Hospital Association's Task Force for Care of the Medically Indigent. I am pleased to be here today to discuss the very serious problem of health care for the uninsured. With me is John Billings, the expert consultant that worked with DCHA in conducting this study.

In basic terms, we are speaking today of whether we believe that health care is a right or a privilege. Is access to health care limited to those who can pay, or do we believe that everyone, regardless of ability to pay, should be able to obtain needed health care services?

Our entire payment system is structured in such a way that it defines health care as a privilege, but our common sense tells us that, like public education, health care should be available to everybody.

The District of Columbia Hospital Association became actively involved in this issue of health care for the uninsured in 1985. Local surveys were done at that time to obtain details about the financial burden of charity care. The Task Force for the Care of the Medically Indigent was formed. The initial report of that task force, some 2½ years ago, indicated that we did not know enough about the uninsured patients who use District hospitals. Thus, the DCHA board of directors and the hospital they represent commissioned and funded a project to be conducted by the Washington-based national consulting firm of Lewin/ICF. My testimony today will focus on the findings of that study, which was conducted in 1988.

First, let me say that the wealth of information that we have gained as a result of this project could not have been done without the cooperation of the 18 hospitals in the District and the District of Columbia's Commission of Public Health. It was a joint effort by all of us, which has had a resounding impact not just here in Washington, but across the country.

The project was divided into four parts. I will move briefly through the first three because I know your interest is primarily in part 4. However, the first three will help provide the background for the last.

Part 1 used census data to develop general statistics about the uninsured population in the District and comparisons to the metropolitan area and to the United States. You might follow me in the tables as suggested in this testimony.

These numbers showed that the District has more than double the uninsured population of the surrounding metropolitan area. Over 20 percent of the people in the District have no insurance.

That means that over 110,000 people have no insurance. Nationally, almost 18 percent are uninsured. In the outlying suburbs of Washington, only 9 percent are uninsured.

The second part of the project looked at the cost of uncompensated care, and I underline cost, to District hospitals. The dollar total for unsponsored care in D.C. hospitals in 1987 was nearly $160 million. If we subtract out the Federal subsidies, local and Federal subsidies, the total was $100 million. While these numbers are dramatic, what is of even greater concern is uncompensated care expressed as a percent of total cost. For the District, it is 9 percent, up from 7.5 percent only 3 years ago.

Let me use my hospital as an example. George Washington University Medical Center is a 500-bed teaching facility at 23d and Eye Streets, about six blocks down from the White House. While this may sound like a wealthy neighborhood, you should be aware that in fiscal year 1988, our institution provided $24 million in free care, including about $2 million to homeless residents. The bottom line showed losses for the institution of nearly $6 million.

You may say that is admirable and that we should be commended, but I must tell you that the George Washington University Medical Center cannot go on at this rate.

Part 3 of the study took a look at exactly who the indigent population was. It was a result of interviews with uninsured patients who were admitted as inpatients to D.C. hospitals during a 1-month period in the spring of 1988. They were asked about health services they had received prior to their admission. Among the results were the facts: Over 85 percent were admitted on an emergency basis; nearly 40 percent has no usual source of primary or outpatient care; three-quarters of them had no single health care practitioner in charge of their care; more than 40 percent reported an access problem to primary or outpatient care, and the vast majority of those stated cost as the major reason. No surprise.

When evaluated by hospital quality assurance staff, it was discovered that over one-third of uninsured patients—and that is not including obstetric and trauma—could have avoided the hospital admission had they received primary or outpatient care in a timely manner. If a patient had a single practitioner in charge of his or her care, the rate of "avoidable" admissions was cut in half, dramatizing the need for consistent, regular outpatient care.

We have learned many other facts about the demographics of the uninsured patient who used D.C. hospital services, but the facts I have just shared with you relate more directly to the points to be made in the final section of the study in which you have expressed your interest.

Part 4 of the study is what is called a small area analysis. A small area analysis is a method of measuring and comparing the use of hospital care, defined by populations. For this study, the researchers used 1985 data and developed admission rates according to diagnosis by Zip Code. For many conditions that are not sensitive to outpatient management, such as surgery, there was no significant difference.

However, the findings for many medical conditions showed that patients in poorer sections of the District of Columbia were admitted at startling higher rates for diagnoses that are well suited to

management in a primary or outpatient care setting. Highlights from the analysis include the following points:

For adult pneumonia, patients in the Adams Morgan section of the District, which has the lowest median income of any of the geographic sections in the study, were admitted to the hospital at a rate over 21 times that of people who live in Bethesda, Maryland; For adult bronchitis, patients in Congress Heights, which is in far Southeast D.C., were admitted at a rate 25 times higher than those in Cleveland Park.

Chairman STARK. Aren't these also cases that normally should never get to a hospital?

Mr. BARCH. Well, as seen in the graphs, in the case of those receiving primary care, that is exactly right.

Chairman STARK. Hypertension is not a hospital illness?

Mr. BARCH. Unless it gets out of control, yes.

Chairman STARK. Yes. Or diabetes?

Mr. BARCH. Unless it gets out of control.

Chairman STARK. Heart failure, maybe. I do not know about that. But little kid's pneumonia, whatever you call that.

Mr. BARCH. In summary, I guess, we would have to agree with the Honorable Mr. Rogers who preceded us, and this needs to be dealt with in a systemic fashion that what we are looking at is a multifaceted solution to the problem facing you. We certainly believe that the money is in the system today if we redirect it in a sensible fashion.

[The statement of Mr. Barch follows:]

TESTIMONY OF MICHAEL M. BARCH, VICE CHAIRMAN
THE DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION TASK FORCE
FOR THE CARE OF THE MEDICALLY INDIGENT

GOOD MORNING, MR. STARK AND MEMBERS OF THE COMMITTEE. MY NAME IS MICHAEL BARCH. I AM THE DIRECTOR OF ADMINISTRATIVE AFFAIRS AT THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER HERE IN THE DISTRICT OF COLUMBIA, AND I AM THE CO-CHAIRMAN OF THE DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION'S TASK FORCE FOR CARE OF THE MEDICALLY INDIGENT. I AM PLEASED TO BE HERE TODAY TO DISCUSS THE VERY SERIOUS PROBLEM OF HEALTH CARE FOR THE UNINSURED.

IN BASIC TERMS, WE ARE SPEAKING TODAY OF WHETHER WE BELIEVE THAT HEALTH CARE IS A RIGHT OR A PRIVILEGE. IS ACCESS TO HEALTH CARE LIMITED TO THOSE WHO CAN PAY? OR, DO WE BELIEVE THAT EVERYONE, REGARDLESS OF ABILITY TO PAY, SHOULD BE ABLE TO OBTAIN NEEDED HEALTH SERVICES?

I THINK, IN AMERICA, WE ARE A BIT SCHIZOPHRENIC ON THIS ISSUE. OUR ENTIRE PAYMENT SYSTEM IS STRUCTURED IN SUCH A WAY THAT IT DEFINES HEALTH CARE AS A PRIVILEGE. BUT OUR COMMON SENSE TELLS US THAT LIKE PUBLIC EDUCATION, HEALTH CARE SHOULD BE AVAILABLE TO EVERYBODY.

THE DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION (DCHA) BECAME ACTIVELY INVOLVED IN THE ISSUE OF HEALTH CARE FOR THE UNINSURED IN 1985. LOCAL SURVEYS WERE DONE AT THAT TIME TO OBTAIN DETAILS ABOUT THE FINANCIAL BURDEN OF CHARITY CARE; THE TASK FORCE FOR CARE OF THE MEDICALLY INDIGENT WAS FORMED. THE INITIAL REPORT OF THAT TASK FORCE, SOME TWO-AND-A-HALF YEARS AGO, INDICATED THAT WE DID NOT KNOW ENOUGH ABOUT THE UNINSURED PATIENTS WHO USE DISTRICT HOSPITALS. THUS, THE DCHA BOARD OF DIRECTORS, AND THE HOSPITALS THEY REPRESENT, COMMISSIONED AND FUNDED A PROJECT TO BE CONDUCTED BY THE WASHINGTON-BASED, NATIONAL CONSULTING FIRM OF LEWIN/ICF.

MY TESTIMONY TODAY WILL FOCUS ON THE FINDINGS OF THAT STUDY, WHICH WAS CONDUCTED IN 1988.

FIRST, LET ME SAY THAT THE WEALTH OF INFORMATION WE HAVE GAINED AS A RESULT OF THIS PROJECT COULD NOT HAVE BEEN DONE WITHOUT THE COOPERATION OF THE EIGHTEEN HOSPITALS IN THE DISTRICT AND THE DISTRICT OF COLUMBIA'S COMMISSION OF PUBLIC HEALTH. IT WAS A JOINT EFFORT BY ALL OF US, WHICH HAS HAD A RESOUNDING IMPACT, NOT JUST HERE IN WASHINGTON, BUT ACROSS THE COUNTRY.

THE PROJECT WAS DIVIDED INTO FOUR PARTS. I WILL MOVE BRIEFLY THROUGH THE FIRST THREE, BECAUSE I KNOW YOUR INTEREST IS PRIMARILY IN PART FOUR. HOWEVER, THE FIRST THREE WILL HELP PROVIDE THE BACKGROUND FOR THE LAST.

PART ONE:

PART ONE USED CENSUS DATA TO DEVELOP GENERAL STATISTICS ABOUT THE UNINSURED POPULATION IN THE DISTRICT, AND COMPARISONS TO THE METROPOLITAN AREA AND TO THE UNITED STATES. (See Appendix, page 11-13)

THESE NUMBERS SHOWED THAT THE DISTRICT HAS MORE THAN DOUBLE THE UNINSURED POPULATION OF THE SURROUNDING METROPOLITAN AREA - OVER 20 PERCENT OF THE PEOPLE IN THE DISTRICT HAVE NO INSURANCE. THAT MEANS THAT OVER 110,000 PEOPLE HAVE NO PRIVATE INSURANCE, NO BLUE CROSS, NO MEDICAID, NO MEDICARE. NATIONALLY, ALMOST 18 PERCENT ARE UNINSURED. ONLY 9 PERCENT OF THOSE IN THE SUBURBAN JURISDICTIONS SURROUNDING D.C. ARE UNINSURED.

WHAT ELSE DO WE KNOW ABOUT THE UNINSURED IN D.C.? HERE ARE A FEW ADDITIONAL FACTS EXTRAPOLATED FROM CENSUS DATA:

* NEARLY HALF HAVE INCOME UNDER 150 PERCENT OF THE POVERTY LEVEL (ABOUT $17,000 FOR A FAMILY OF FOUR);
* 40 PERCENT HAVE JOBS, AND OVER 80 PERCENT ARE IN FAMILIES WHERE AT LEAST ONE PERSON HAS A JOB;
* ALMOST 70 PERCENT OF UNINSURED WORKERS HAVE JOBS IN THE SERVICE AND RETAIL INDUSTRIES.

THESE STATISTICS ARE SIMILAR TO OTHER URBAN AREAS, BUT WHAT SETS THE DISTRICT OF COLUMBIA APART IS THAT WE ARE JURISDICTIONALLY CUT OFF FROM OUR SUBURBS. WHERE OTHER CENTRAL CITIES CAN GET HELP IN CARING FOR THE UNINSURED FROM SURROUNDING SUBURBS, THE DISTRICT CANNOT.

PART TWO:

THE SECOND PART OF THE PROJECT LOOKED AT THE COSTS OF UNCOMPENSATED CARE TO DISTRICT HOSPITALS. (See Appendix, pages 14-18)

THE DOLLAR TOTAL FOR UNSPONSORED CARE IN D.C. HOSPITALS IN 1987 WAS NEARLY $160 MILLION; WITHOUT THE LOCAL AND FEDERAL SUBSIDIES, THE TOTAL IS JUST OVER $100 MILLION. WHILE THESE NUMBERS ARE DRAMATIC, WHAT IS OF EVEN GREATER CONCERN IS UNCOMPENSATED CARE EXPRESSED AS A PERCENT OF TOTAL COSTS. FOR THE DISTRICT, IT IS 9 PERCENT, UP FROM 7.5 PERCENT ONLY THREE YEARS AGO. THAT'S EQUIVALENT TO A BUSINESS THAT OPERATES AT A 9 PERCENT ANNUAL LOSS.

SUCH UNCOVERED COSTS NOT ONLY PLACE A DIRECT FINANCIAL BURDEN ON ALL HOSPITALS, BUT FOR THOSE HOSPITALS IN THE DISTRICT OF COLUMBIA, IT HAS AN INDIRECT EFFECT AS WELL... TO COMPENSATE FOR THE SIGNIFICANT LOSSES IN PROVIDING THIS UNSPONSORED CARE, D.C. HOSPITALS MUST RAISE THEIR PRICES TO COVER THEM; THIS PUTS D.C. HOSPITALS AT A DIRECT COMPETITIVE DISADVANTAGE WITH HOSPITALS IN MARYLAND AND VIRGINIA FOR THE WELL-INSURED, PAYING PATIENTS.

IT IS ALSO IMPORTANT TO NOTE THAT THE URBAN HOSPITALS WHICH SERVE THE POOREST PEOPLE ARE THE MOST FINANCIALLY FRAGILE. AND A HOSPITAL IN THIS TYPE OF CONDITION MAY EVENTUALLY BE FORCED TO CLOSE ITS DOORS... AND A CLOSED HOSPITAL SERVES NO ONE, NOT EVEN PAYING PATIENTS.

LET ME USE MY HOSPITAL AS AN EXAMPLE. GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER IS A 500-BED TEACHING FACILITY AT 23RD AND EYE STREETS, NEAR THE STATE DEPARTMENT COMPLEX. WHILE THIS MAY SOUND LIKE A WEALTHY NEIGHBORHOOD, YOU SHOULD BE AWARE THAT IN FY 1988, OUR INSTITUTION PROVIDED $24 MILLION DOLLARS IN FREE CARE, INCLUDING $2 MILLION TO HOMELESS RESIDENTS. THE BOTTOM LINE SHOWED LOSSES TO THE INSTITUTION OF NEARLY $6 MILLION.

YOU MAY SAY THAT THIS IS ADMIRABLE, AND THAT WE SHOULD BE COMMENDED, BUT I MUST TELL YOU THAT GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER CANNOT GO ON AT THIS RATE. WE HAVE BEEN TRAINING MEDICAL STUDENTS FOR OVER 130 YEARS, BUT IF WE CONTINUE TO OPERATE IN THE "RED" YEAR AFTER YEAR, WE MAY HAVE TO STOP.

HOSPITALS DO HAVE THEIR MISSIONS TO SERVE, BUT LOSSES OF THIS MAGNITUDE BEGIN TO MAKE SUCH SERVICE NOT JUST IMPRACTICAL, BUT IMPOSSIBLE.

PART THREE:

THE THIRD PART OF THE INDIGENT CARE PROJECT COMPILED THE RESULTS OF INTERVIEWS WITH UNINSURED PATIENTS WHO WERE ADMITTED (AS INPATIENTS) TO D.C. HOSPITALS DURING A ONE-MONTH PERIOD IN THE SPRING OF 1988. THEY WERE ASKED ABOUT HEALTH SERVICES THEY HAD RECEIVED PRIOR TO THEIR ADMISSION. AMONG THE RESULTS WERE THESE FACTS (KEEP IN MIND THAT THESE REFER ONLY TO UNINSURED PATIENTS): (See Appendix, page 19-29)

* OVER 85 PERCENT WERE ADMITTED ON AN EMERGENCY BASIS;

* NEARLY 40 PERCENT HAD NO USUAL SOURCE OF PRIMARY OR OUTPATIENT CARE;

* THREE QUARTERS OF THEM HAD NO SINGLE HEALTH CARE PRACTITIONER IN CHARGE OF THEIR CARE;

* MORE THAN 40 PERCENT REPORTED AN ACCESS PROBLEM TO PRIMARY OR OUTPATIENT CARE, AND THE VAST MAJORITY OF THOSE STATED COST AS THE MAJOR REASON;

* WHEN EVALUATED BY HOSPITAL QUALITY ASSURANCE STAFF, IT WAS DISCOVERED THAT OVER ONE-THIRD OF UNINSURED PATIENTS (NON-OBSTETRIC, NON-TRAUMA) COULD HAVE AVOIDED THE HOSPITAL ADMISSION HAD THEY RECEIVED PRIMARY OR OUTPATIENT CARE IN A TIMELY MANNER. IF A PATIENT HAD A SINGLE PRACTITIONER IN CHARGE OF HIS/HER CARE, THE RATE OF "AVOIDABLE" ADMISSION WAS CUT IN HALF, DRAMATIZING THE NEED FOR CONSISTENT, REGULAR OUTPATIENT CARE.

WE HAVE LEARNED MANY OTHER FACTS ABOUT THE DEMOGRAPHICS ABOUT UNINSURED PATIENTS WHO USE D.C. HOSPITAL SERVICES, BUT THE FACTS I HAVE JUST SHARED WITH YOU RELATE MOST DIRECTLY TO THE POINTS TO BE MADE IN THE FINAL SECTION OF THE STUDY IN WHICH YOU HAVE EXPRESSED YOUR INTEREST.

PART FOUR:
THE FINAL PART OF THE STUDY IS WHAT IS CALLED A "SMALL AREA ANALYSIS." (See Appendix, pages 29-41)

A SMALL AREA ANALYSIS IS A METHOD OF MEASURING AND COMPARING THE USE OF HOSPITAL CARE, DEFINED BY POPULATIONS. FOR THIS STUDY, THE RESEARCHERS USED 1985 DATA AND DEVELOPED ADMISSION RATES ACCORDING TO DIAGNOSIS BY ZIP CODE. FOR MANY CONDITIONS THAT ARE NOT SENSITIVE TO OUTPATIENT MANAGEMENT, SUCH AS SURGERY AND INGUINAL HERNIA, THERE WAS NO SIGNIFICANT DIFFERENT.

HOWEVER, THE FINDINGS FOR MANY MEDICAL CONDITIONS SHOWED THAT PATIENTS IN POORER SECTIONS OF THE DISTRICT OF COLUMBIA WERE ADMITTED AT STARTLING HIGHER RATES FOR DIAGNOSES THAT ARE WELL-SUITED TO MANAGEMENT IN A PRIMARY OR OUTPATIENT CARE SETTING. HIGHLIGHTS FROM THE ANALYSIS INCLUDE THE FOLLOWING POINTS:

* FOR ADULT PNEUMONIA, PATIENTS IN THE ADAMS MORGAN SECTION OF THE DISTRICT (WHICH HAS THE LOWEST MEDIAN INCOME OF ANY OF THE GEOGRAPHIC SECTIONS IN THE STUDY) WERE ADMITTED TO THE HOSPITAL AT A RATE OVER 21 TIMES THAT OF PEOPLE WHO LIVE IN BETHESDA, MARYLAND; THAT'S 2100%!

* FOR ADULT BRONCHITIS, PATIENTS IN CONGRESS HEIGHTS (IN FAR SOUTHEAST D.C.) WERE ADMITTED AT A RATE 2500% HIGHER THAN IN CLEVELAND PARK (IN UPPER NORTHWEST D.C.);

* FOR HYPERTENSION, PATIENTS IN CONGRESS HEIGHTS WERE ADMITTED AT A RATE 1900% HIGHER THAN IN FAIRFAX, VIRGINIA;

* FOR DIABETES, PATIENTS IN CONGRESS HEIGHTS WERE ADMITTED AT A RATE 2000% HIGHER THAN THOSE IN GEORGETOWN;

AND THIS PHENOMENON IS NOT LIMITED TO ADULTS; CHILDREN, TOO, ARE AFFECTED:

* FOR PEDIATRIC BRONCHITIS, CHILDREN IN ANACOSTIA (ALSO IN SOUTHEAST D.C.) WERE ADMITTED AT A RATE 900% HIGHER THAN CHILDREN IN BETHESDA;

* FOR PEDIATRIC PNEUMONIA, CHILDREN IN CONGRESS HEIGHTS WERE ADMITTED AT A RATE 600% HIGHER THAN THOSE IN CHEVY CHASE.

THIS PATTERN IS ALSO PRESENT FOR THE AGE 65 AND OLDER POPULATION, ALTHOUGH MUCH LESS PRONOUNCED, SUGGESTING THAT THE ALMOST UNIVERSAL COVERAGE AFFORDED BY MEDICARE MAY HELP TO REDUCE ACCESS PROBLEMS FOR OLDER PATIENTS.

WHAT THIS SMALL AREA ANALYSIS CONFIRMS IS THAT DIAGNOSES FOR WHICH INSURED PEOPLE ARE TREATED BY THEIR FAMILY DOCTORS OR THEIR HMOs, POOR PEOPLE ARE TREATED IN HOSPITALS AT VERY LATE STAGES IN THEIR ILLNESSES.

HOSPITALS, THEN, HAVE BECOME THE PRIMARY CARE SAFETY NET FOR THE UNINSURED.

SUMMARY:
SEVERAL CONCLUSIONS SHOULD BE DRAWN FROM THE DCHA PROJECT:

* UNINSURED PEOPLE APPEAR TO PUT OFF CARE UNTIL THEIR CONDITION BECOMES AN EMERGENCY; THEN THEY GO TO HOSPITALS WHERE THEY KNOW THEY WILL RECEIVE CARE.

* ACCESS TO PRIMARY CARE IS THE REAL PROBLEM. WE MUST DIRECT OUR ATTENTION TO IMPROVING THIS PART OF THE HEALTH CARE CONTINUUM FOR THE UNINSURED. HERE IN D.C., HOSPITALS ARE WORKING WITH THE COMMISSIONER OF PUBLIC HEALTH TO ASSIST IN IMPROVING PUBLIC CLINICS, AND TO ENCOURAGE PATIENTS WITH PRIMARY AND OUTPATIENT CARE NEEDS TO SEEK SERVICES IN THESE SITES, RATHER THAN IN HOSPITAL EMERGENCY ROOMS.

* UNINSURED PATIENTS FACE FINANCIAL BARRIERS, BOTH REAL AND PERCEIVED TO PRIMARY CARE SERVICES, WHICH IS WHY WE FIND THEM IN HOSPITAL EMERGENCY ROOMS WITH THE FLU, A COLD, OR A SPRAIN.

* AS A RESULT OF THE UNINSURED USING EMERGENCY ROOMS AS FAMILY PHYSICIANS, THEIR CARE IS MORE EXPENSIVE THAN CARE FOR AN INSURED PERSON WHO USES A PHYSICIAN'S OFFICE OR OTHER PRIMARY CARE SITE. IN ADDITION TO THE HIGH COSTS OF WHERE THEY RECEIVE CARE, UNINSURED PATIENTS TEND TO OBTAIN LESS TIMELY AND LESS REGULAR PRIMARY CARE, SO THEIR CONDITIONS TEND TO BE MORE SEVERE, AND THUS THE COST OF THEIR CARE IS MORE.

* FINALLY, EDUCATIONAL PROGRAMS NEED TO BE TARGETED AT THE UNINSURED (AND OTHERS) TO IMPROVE THEIR UNDERSTANDING OF WHERE TO OBTAIN THE APPROPRIATE HEALTH CARE SERVICES.

THIS PROJECT HAS HELPED US TO UNDERSTAND MORE CLEARLY THE PROBLEMS OF PROVIDING AND FINANCING CARE FOR THE UNINSURED AND MEDICALLY INDIGENT. OUR WORK, HOWEVER, HAS ONLY BEGUN.

THE DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION AND ITS 18 HOSPITAL MEMBERS HAVE INITIATED A PROCESS HERE IN THE DISTRICT WHICH HAS IDENTIFIED THE UNINSURED POPULATION, THE CARE THEY NEED, AND THE BARRIERS TO THEM IN RECEIVING THAT CARE. WE ARE HOPEFUL THAT YOUR COMMITTEE AND THE CONGRESS, THE DISTRICT OF COLUMBIA'S COMMISSION OF PUBLIC HEALTH, AND PRIVATE SECTOR AGENCIES CAN JOIN WITH US TO UTILIZE THIS INFORMATION TO ESTABLISH CREATIVE PROJECTS TO ADDRESS THESE NEEDS. IT IS NOT A SIMPLE TASK, BUT DCHA, ITS BOARD, AND ITS MEMBERS STAND READY TO ASSIST IN WHATEVER WAYS WE ARE ABLE.

THANK YOU FOR THE OPPORTUNITY TO ADDRESS THE COMMITTEE. I WILL BE HAPPY TO RESPOND TO ANY QUESTIONS YOU MIGHT HAVE.

Mr. BARCH. I would also like, Mr. Chairman, if I could ask Mr. Billings, who is a true expert in this area, to make a few comments.

Mr. BILLINGS. Let me just reiterate two points that were raised by the committee. One was raised by Representative Johnson. That is that oftentimes an insurance card is not enough to solve this problem, and our data demonstrate that very effectively. Having a Medicaid card in the District cut down some of these problems but did not cut it down all the way. They still had very serious problems, even with the Medicaid card. So just giving insurance cards out to people, especially low-income people, is not going to be enough to solve the problem.

Chairman STARK. Why is that?

Mr. BILLINGS. Because there are other problems that have nothing to do with not being able to get to a doctor's office and getting your bill paid. It has to do with cultural things, transportation, outreach, child care and so forth to get into the doctor's office. Those turned out to be very serious barriers to the low-income people in the District.

In the Medicaid case, there is also some evidence suggesting in many jurisdictions that the payment levels are low enough that many practitioners do not want to take the Medicaid patients.

The second point is one that Mike made just at the end, and that is that what our data suggest is something a little new. That is, that there may be enough money in the system to solve this problem. So then it becomes a political problem of deciding out of whose pocket you are going to take it and then put it back into other pockets. So it is a matter of reallocating resources, not taking money from other sectors of the economy and putting it into health.

Mr. BARCH. There was some other interesting data, as we interpreted it. The average age of the uninsured was in the high twenties. We might note that at that age, as I am sure you well remember, you have a real sense of immortality; and the sense of need for health insurance, particularly when you are living from hand to mouth, does not occur to you. So offering the ability to buy insurance is not going to go too far in solving the problem.

Chairman STARK. Mr. Willson.

STATEMENT OF PETERS D. WILLSON, DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS

Mr. WILLSON. Thank you, Mr. Chairman, members of the committee.

My name is Peters Willson. I am the director of government relations for the National Association of Children's Hospitals and Related Institutions. On behalf of children's hospitals, I want to thank you very much for the hearing you are holding this morning and also for the opportunity to present their views. I will submit my statement for the record and summarize it briefly.

Our testimony makes essentially three points. First, children's hospitals have special missions. They are devoted to the care of children with specialized health care needs and often children of

low-income families. And by virtue of their special missions, children's hospitals have often been in a unique position to see firsthand many of the new challenges to children's health and children's access to health care we are experiencing in the 1980's.

Second, children's hospitals recently have undertaken the review of the literature and research in the field on children's health and access to care, and have published the findings in a publication of which you have copies, "Profile of Child Health in the United States." That publication makes the point that both nationwide and in our individual hospitals, we are seeing quite significant new challenges to child health and to access to care.

Finally, in our testimony, we make two basic recommendations for Congress, which already have been, in part, presented earlier by Dana Hughes. First, we strongly support immediate steps to continue Congress' move toward expanding Medicaid coverage for the most vulnerable among the uninsured: low-income and near-poor pregnant women, infants, and children. And, second, at the same time we also support moves toward more comprehensive reform in health coverage for all children that builds on the capabilities and the responsibilities of both the public and private sectors.

Now, having summarized those three points, let me say that in looking at the research and the literature, we essentially reviewed the major studies of many respected groups, including the work cited by Dana Hughes from the Children's Defense Fund. And what that showed is that there are quite significant, and even in some cases dramatic, challenges to children's health and access to care. Rather than cite the statistics, I would like to give you some examples of those challenges from the experiences of individual children's hospitals around the country.

One place to start is the problem of AIDS. Certainly, there is no more dramatic or obvious example of a new challenge to health in America. And that is true of children at risk of HIV infection. Children's Hospital Oakland in California, in 1983, saw just one case of a child with AIDS. Today, that same hospital is following more than 40 cases. They project them to be doubling on an annual basis. Those cases are children who, compared to individuals with comparable diagnoses, have significantly longer lengths of stay, significantly more intensive care needs, and substantially more complex social as well as medical care needs.

The same can be said whether we are talking about children's hospitals in Seattle or Boston or Chicago or other cities around the country.

Another example that has been briefly mentioned this morning: Even a decade ago, we did not see the many children who today are surviving by virtue of mechanical assistance in breathing. They live literally because they are ventilator-dependent.

In 1981, Children's Hospital Medical Center in Cincinnati, Ohio, provided about 1,500 patient days of care a year for children with such ventilator dependence. Last year, they provided close to 6,000 patient days. This coming year, they project that will increase to 7,000 patient days. Again, their experience is not unique when one looks at children's hospitals in Pittsburgh or in other cities around the country.

A third example: Who among us I think even a few years ago would have expected that we would begin to see outbreaks of childhood diseases previously expected to be prevented by immunization? But as immunization rates have fallen back in recent years, we are seeing the experience of hospitals such as Children's Hospital of Michigan in Detroit. Last year, that hospital saw six cases of children with pertussis—whooping cough—cases that were all long length-of-stay cases which resulted in serious neurological damage in some instances, even death in one case.

Perhaps more dramatic is the current experience of Texas Children's Hospital in Houston. Three years ago, that hospital saw no cases of children with measles, nor 2 years ago. Last year, it saw 15. In the first 3 months of this year, the hospital has already seen 38 cases of measles.

These kinds of challenges not only to health but also to the ability to provide access to care for these children are significant, and it is the combination of the research in the field and our hospitals' individual experiences that have led children's hospitals to express very strongly support for enactment of the Medicaid reform measures introduced this year by Congressmen Leland and Waxman and Hyde, to specifically build on the steps Congress has taken in the last few years to to expand Medicaid coverage for low-income pregnant women, infants, and children.

At the same time, we also strongly support more comprehensive efforts to provide health care coverage for all children, and we believe strongly that those measures obviously must build on the capabilities of both the private and the public sectors. Proposals that deal with employer-provided health coverage are important steps in that direction.

Now, I would say by way of conclusion that children's hospitals, in expressing both their concerns and their commitments to improved public and private coverage, recognize that that brings with it an important responsibility for cost control and quality of care, as has been discussed this morning. And I would point, as an example of children's hospitals' own commitment in that area, to the work that we have undertaken in recent years with the support of the Health Care Finance Administration to develop what we call pediatric modified diagnosis-related groups. In effect, we have developed a revised classification system which is useful for both prospective payment and individual hospital management for pediatric care.

It may be of interest to you to know that the work that our association undertook in this area provided the basis recently for the Defense Department to develop a revised CHAMPUS prospective payment system which, for the first time, will be applied to the provision of care, both for children under CHAMPUS receiving care in children's hospitals and neonates receiving care in general or community hospitals.

With that, I would like to conclude my remarks and thank you again for the opportunity to present Children's Hospitals views and to say I would be glad to try to answer any questions you have now or for the record.

[The statement of Mr. Willson follows:]

STATEMENT OF PETERS D. WILLSON
DIRECTOR OF GOVERNMENT RELATIONS
NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS

Mr. Chairman and members of the subcommittee, I am Peters D. Willson, director of government relations for NACHRI -- the National Association of Children's Hospitals and Related Institutions. I am also a member of the Board of Directors of the Children's Inn at NIH and a volunteer in the Infants and Toddlers Unit of Children's Hospital National Medical Center in Washington, D.C.

On behalf of NACHRI, I want to commend you for the hearing you are holding this morning, and I want to express our appreciation for the opportunity you have given children's hospitals to address the status of children's health and the need for insurance to give children access to care.

NACHRI is the only national, voluntary association of children's hospitals. It represents more than 100 institutions in the United States and Canada. Virtually all of NACHRI's members are teaching hospitals and involved in conducting research. Most are also regional medical centers receiving referrals from larger geographic regions in the U.S. and from around the world. Among health care providers, children's hospitals are unique because of their missions of service to:

- o children who are very sick;
- o children with specialized health care needs; and
- o children whose families often have very low incomes.

There is a children's hospital in the home community or state of each member of your subcommittee.

In my testimony this morning, I would like to emphasize three points for you:

- o First, by virtue of their special missions, children's hospitals are in a unique position to see first-hand emerging challenges to children's health and their access to care. In recent years, children's hospitals have been disturbed by changes in children's health and health coverage among their patients.

- o Second, a recent review of the published research and literature on children's health status nationwide confirms the first-hand experience of individual children's hospitals: the health of our nation's children is compromised, because of new challenges to health and because of deterioration in children's health care coverage. NACHRI has highlighted these facts in a new publication, Profile of Child Health in the United States.

- o Third, as a result of their individual experiences and the findings of published research, children's hospitals are giving strong support to immediate steps Congress can take to improve health care access for the most vulnerable -- children living in poverty without health care coverage. At the same time, NACHRI is committed to working with others, including this subcommittee, to develop more comprehensive responses to meet the health care needs of millions of uninsured as well as under-insured families and their children. We are convinced that such proposals must build on the capabilities of both the private and

the public sectors. They also should be designed both to encourage cost effective service delivery and to ensure quality care. The two must go hand in hand.

Children's Hospitals' Experience

During the 1980s, children's hospitals experienced significant changes in the kinds of health care problems requiring their care and in the availability of adequate health insurance coverage for the provision of such care. I would like to give you some examples of the experience of individual hospitals in your home states:

o In 1983, Children's Hospital Oakland, in Oakland, CA, saw only one case of a child with AIDS. Today, it is following more than 40 cases of children exposed to HIV. Almost all of these children are two years or younger. Although most are covered, many are under-insured.

o Since 1986, Children's Hospital Medical Center in Cincinnati, Ohio, has treated 105 cases of children born with a severe breathing disorder, using a new technology commonly called ECMO -- extracorporeal membrane oxygenation. Before 1986, more than 90 percent of the children born with this condition did not survive. Today, the hospital can save more than 85 percent. About 40 percent of these children are uninsured or under-insured.

o In the early 1980s, Children's Hospital of Michigan in Detroit, MI, saw virtually no cases of pertussis (whooping cough), which is preventable along with other infectious diseases by routine childhood vaccination. In 1988 the hospital gave care for six children with pertussis. Of them, all had long lengths of stay, one died, and another suffered serious neurological damage.

o In 1981, Cincinnati Children's had 1,500 patient days devoted to the care of children who are "ventilator-dependent" -- they depend on mechanical assistance to breathe and survive. Last year, the hospital gave more than 5,800 patient days of care to these children. Of them, 90 percent were uninsured or under-insured.

The experiences of these hospitals are typical of children's hospitals around the country, which repeatedly are in the forefront of providing innovative acute and primary care to children. For example, several children's hospitals have emerged as models of comprehensive care for children with HIV infection -- a condition unknown less than a decade ago. Children's hospitals have become leaders in the delivery of intensive care for newborn infants in the first month of life, making possible the survival of children who would not have lived beyond birth even a few years ago. And because they often are located in inner-city neighborhoods and were founded with missions of caring for children of indigent families, children's hospitals are among the first to see seriously ill children who have not had the benefit of even routine health care.

Profile of Child Health

Experiences like these in individual children's hospitals in the 1980s persuaded NACHRI's member institutions to try to assess the health status of children nationwide, joining others who already had begun to alert the country to serious problems confronting children's health and access to health care.

In 1987, NACHRI established a Council on Child Health for its member hospitals. It is comprised of representatives of the many professions of people who work together in children's hospitals: physicians, nurses, social workers, volunteer trustees, finance specialists, administrators, and public affairs specialists. Working with NACHRI staff, the Council looked at available research published by individual researchers as well as respected organizations such as the American Academy of Pediatrics, the American Public Health Association, the Children's Defense Fund, and many others. The Council reviewed reports about different health conditions among children, different groups of children most at risk of poor health, and different barriers to children's access to health care.

NACHRI has published the Child Health Council's review in a publication entitled Profile of Child Health in the United States. Reading this publication, as well as the published works of so many groups upon which it is based, can lead you to only one conclusion: At the same time that we have seen growing numbers of children without health care insurance -- a key determinant of access to health care -- we find the health of America's children compromised by what might be called the "new morbidities:" chronic illness, child abuse and neglect, poor dietary habits, a high rate of accidental death and disability, and mental health problems.

Children's Health Status

Perhaps the best way to illustrate this conclusion is to consider an important finding of public health experts: At the current rate of progress, the nation will fail to meet nearly all of the U.S. Surgeon General's 1990 Health Objectives related to the health of pregnant women and infants, which were established almost a decade ago. (1) Three different examples illustrate what the failure to meet the Surgeon General's objectives means:

o The health of a child begins with the health of the mother. That is why in 1980, the Surgeon General recommended that by 1990, the proportion of women in any county or racial or ethnic group who obtain no prenatal care during the first three months of pregnancy should not exceed 10 percent. (2) Yet, since 1978 there has been virtually no reduction in the percentage of pregnant women receiving late or no prenatal care. (3) In 1985, 23.8 percent of all pregnant women received no prenatal care during the first three months of pregnancy; 38.2 percent of black women, 39.7 percent of American Indian women, and 38 percent of Hispanic women did not. (4)

o In 1980, the Surgeon General recommended that at least 90 percent of all children should have completed their basic series of immunizations by age two -- measles, mumps, rubella, polio, diphtheria, pertussis, and tetanus. (5) Yet, between 1976 and 1985, the proportion of pre-school age children who were immunized against each of these childhood diseases leveled off or

declined. (6) In 1984, less than 75 percent of two year old children were vaccinated against polio; less than 77 percent against mumps; less than 79 percent against rubella; less than 82 percent against measles; less than 86 percent against DPT. (7)

o In 1980, the Surgeon General recommended that injuries and deaths to children inflicted by abusing parents should be reduced by at least 25 percent by 1990. (8) Yet, according to a national survey, between 1981 and 1985, the number of children reported to have been abused or neglected rose 54.9 percent. (9)

Children at Risk

Having reviewed the health status of children, NACHRI's Council then considered available research on which children are most at risk for compromised health. Studies point to five groups of children:

o "Medically homeless" children: Millions of children can be considered "medically homeless" -- they do not receive routine medical care. Research shows that only 54 percent of uninsured children have seen a physician, compared to 74 percent of privately insured children. (10) Because they have inadequate or no health insurance at all, the families of these children frequently rely on emergency rooms for their health care.

o Children of low income families: In 1985, 20.1 percent of all children were living in families with incomes below the federal poverty level, compared to 14.9 percent in 1970. (11) They included 15.6 percent of white children, 39.6 percent of Hispanic children, and 43.1 percent of black children. (12)

o Minority children: According to research on a variety of different health conditions and measures of health status, black, Hispanic, and American Indian children are at greater risk for inadequate prenatal care, low birth weight, inadequate immunizations, and teenage pregnancy, while white children are at greater risk for suicide, motor vehicle accidents, and obesity. For example, in 1985 black children were more than twice as likely to be born with a low birth weight (less than 2,500 grams) than white children -- yet, low birth weight is a leading cause of death among children at birth. (13) Compared to white women, black women are more than twice as likely to receive inadequate prenatal care. (14) Hispanic and American Indian women are at even greater risk. (15)

o Children of teenage mothers: While birthrates among teenagers and the percentages of all births to teenage mothers fell significantly between 1970 and 1985, the percentage of births to unmarried teenage mothers increased. (16) In 1985, babies born to teenage mothers accounted for only 13.7 percent of all live births, but 19.2 percent of all low birth weight infants in the nation. (17)

o Chronically ill children: Between 10 and 15 percent of children have chronic illnesses of varying levels of severity. (18) Two percent of all children suffer from a major childhood disease such as cystic fibrosis, spina bifida, cancer, leukemia, asthma, and sickle cell anemia. (19) Although small in number, chronically ill children account for 19 percent of hospital discharges for all children and 30 percent of all hospital days for children. (20)

Barriers to Access to Health Care

According to the research reviewed by NACHRI's Council, the most frequently cited barrier to gaining access to health care is financial. Lack of health insurance is a major obstacle to gaining access to health care. (21) Compared to children who had either public or private insurance, children with no insurance have about 40 percent fewer visits to physicians. (22)

In view of that finding, the following facts are especially disturbing:

- In 1986, about 12.2 million children did not have any health insurance, either public or private. They represented about 1 out of every 5 children, and 1 out of every 3 uninsured people. (23)

- From 1979 to 1986, the percentage of all U.S. children who were uninsured increased from 17 to 19 percent, due primarily to the decreasing number of children covered by private insurance. (24)

- In 1984, less than half of all poor children were enrolled in Medicaid, due to state restrictions on eligibility. (25).

In addition to financial barriers, the Council found research pointing to other barriers:

- lack of providers and maldistribution of services;

- lack of prevention and knowledge of health life style; and

- lack of alternative care.

Children's Hospitals' Recommendations for Public Policy

With all of these facts in mind, children's hospitals draw two basic conclusions for federal policy-makers:

- First, Congress should continue as it has in recent years to enact improvements in access to care under Medicaid for the most vulnerable -- children living in poverty who still have no insurance, public or private. That requires legislation that addresses all of the obstacles to access to care under Medicaid: restrictions on children's eligibility for coverage; burdensome application processes that make it difficult to obtain coverage; limitations on the health care services covered; and restrictions on payment for services that make it difficult for providers to ensure continued access to care.

Recently, Sen. Bradley, Rep. Waxman, and Rep. Leland introduced a package of Medicaid reform amendments -- S.339, H.R. 800, 832, and 833 -- that address all of these obstacles to access to care under Medicaid. NACHRI supports enactment of these proposals. In many cases, they complement legislation introduced by other Members of Congress. For example, these bills take a step toward implementing a provision of Rep. Stark's H.R. 751, which would prohibit limits on "the amount, duration, or scope of medical assistance for inpatient hospital services which are medically necessary" under Medicaid.

o Second, NACHRI believes that, as important as such Medicaid reforms are, they are no substitute for comprehensive reform of health care coverage for children. Such reform must build on the distinct capabilities and responsibilities of both the private sector and the public sector. For example, when coupled with Medicaid reform, proposals such as Rep. Stark's "Employee Health Benefits Improvement Act" move toward the more comprehensive reforms that are needed. (NACHRI submitted a statement supporting this type of legislation for the record of the subcommittee's August 9, 1988, hearing on the bill.) By addressing both public and private sector responsibilities for coverage, comprehensive reform can reassure the private sector that it will not bear the burden of cost shifting due to inadequate public coverage for indigent care.

At the same time, such public and private expansions of health care coverage cannot proceed independent of measures to encourage both cost-effective and quality health care services most appropriate to children's needs. Children's hospitals are committed to that goal. For example, during the past several years, NACHRI has worked with the support of the Health Care Financing Administration on the development of PM-DRGs -- pediatric modified diagnosis related groups -- which are appropriate for use in the management of hospital services for children.

NACHRI's work on PM-DRGs became the basis for the development by the U.S. Department of Defense of a revised CHAMPUS prospective payment system specifically for care received by children of military families from either children's hospitals or neonatal services in general hospitals. In addition, PM-DRGs are used by many children's hospitals as part of their ongoing efforts to improve their delivery of services to the children of their communities.

Conclusion

Children's hospitals' first hand experience, confirmed by published research on children's health status nationwide, demonstrates conclusively that substantial steps must be taken to improve children's access to health care. As one immediate step, children's hospitals urge enactment of Medicaid reforms on behalf of low income children, now pending in Congress. Simultaneously, NACHRI is committed to working toward more comprehensive public and private health coverage reform to ensure access to care for all children.

Thank you again for the opportunity to testify. I would be happy to try to answer any questions members of the subcommittee might have.

Footnotes

1. U.S. Centers for Disease Control, "Progress Toward Achieving the 1990 Objectives for Pregnancy and Infant Health," Morbidity and Mortality Weekly Report, U.S. Department of Health and Human Services, Atlanta, GA, July 8, 1988. Vol. 37, No. 6.

2. U.S. Public Health Service, The 1990 Health Objectives for the Nation: A Midcourse Review, U.S. Department of Health and Human Services, Washington, DC, November 1986. p. 51.

3. U.S. Public Health Service, 1986. Table 7, p. 36.

4. U.S. Public Health Service, Health United States, 1987, U.S. Department of Health and Human Services, Washington, DC, March 1988. Table 7, pp. 36-37.

5. U.S. Public Health Service, 1986. p. 68.

6. U.S. Public Health Service, 1988. Table 35, p. 79.

7. U.S. Public Health Service, 1986. p. 69.

8. U.S. Public Health Service, 1986. p. 245.

9. Select Committee on Children, Youth, and Families, Abused Children in America: Victims of Official Neglect, U.S. House of Representatives, Washington, DC, 1987. p. XIII.

10. Judith Kasper, "Children at risk; The uninsured and the inadequately insured," Department of Health Policy and Management, Johns Hopkins School of Hygiene and Public Health, Baltimore, MD, September 1986. p. 14.

11. Select Committee on Children, Youth, and Families, U.S. Children and Their Families: Current Conditions and Recent Trends, U.S. House of Representatives, Washington, DC, 1987. p. 28.

    Also, U.S. Bureau of the Census, Current Population Reports, Series P60, No. 154, U.S. Department of Commerce, Table 16.

12. Select Committee, U.S. Children and Their Families, p. 28.

    Also, U.S. Bureau of the Census, Table 16.

13. U.S. Public Health Service, 1988. p. 36.

14. C. Arden Miller, et.al., Monitoring Children's Health: Key Indicators, American Public Health Association, Washington, DC, 1986. p. 18.

    Also, National Center for Health Statistics, "Advance Report of Final Mortality Statistics, 1983," Monthly Vital Statistics Report 33 (20 Dec). Supplement, DHHS. Pub. No. (PHS) 85-1220, U.S. Department of Health and Human Services, Washington, DC, 1985.

15. Miller, p. 18

16. Karen Pittman and Gina Adams, "Teenage Pregnancy: An Advocate's Guide to the Numbers," Children's Defense Fund, Washington, D.C., January/March 1988. pp. 11-12.

17. Miller, p. 18.

    Also, NCHS, 1985.

18. Paul Newacheck and Margaret McManus, "Financing Health Care for Disabled Children," Pediatrics, March 1988. p. 385.

19. S. Gortmaker and W. Sappenfield, "Chronic Childhood Disorders: Prevalence and Impact,"Pediatric Clinics of North America, 1984. 31(1):3-18.

20. Newacheck, p. 385.

21. M. Rosenbach, "Insurance Coverage and Ambulatory Medical Care of Low-Income Children, United States, 1980," National Medical Care Utilization and Expenditure Survey, (OHHC Publ No. 85-20401), National Center for Health Statistics, U.S. Department of Health and Human Services, 1985. p. 15.

22. Employee Benefit Research Institute, "Public and Private Issues in Financing Health Care for Children," EBRI issue brief, Washington, D.C., June 1988. p. 3.

Also, Stephen Garfinkel, et.al., Health Services Utlization in the U.S. Population by Health Insurance Coverage, National Center for Health Statistics, U.S. Department of Health and Human Services, Washington, D.C., 1986.

23. Deborah Cholet, "Testimony to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives," Employee Benefit Research Institute, Washington, DC, September 22, 1988. p. 1.

24. Margaret McManus, "Dependent coverage eroding in private plans," AAP Children Health Financing Report, American Academy of Pediatrics, Elk Grove Village, IL, Winter 1989. Table 1, p.6.

25. Harriet Fox and Ruth Yoshpe, "Private Health Insurance Coverage of Chronically Ill Children," Report to Congress and the Secretary by the Task Force on Technology Dependent Children, Washington, DC, April 7, 1988. Volume 1, p. 127.

Chairman STARK. I want to thank the panel. The only thing that I would ask of the D.C. Hospital Association is, one, I hope you are going to continue to expand your data base. I think it would be very useful to the committee. Second, if you could in the future, actually by letter would be super, let us know in the—you show in here about approximately $55 million Government subsidies which make up part of the cost burden in the District. If you could project for us what some kind of universal health insurance, say of the magnitude of Medicare, just to pick a benefit level, what it would save both in Federal subsidies and in local subsidies, it would be useful. You are kind of a microcosm of the problem, and it would be helpful if you could submit that later.

Mr. BARCH. We would be happy to do that.

Chairman STARK. Thank you.

[The information of Mr. Barch follows:]

The public burden of payment for health care for the uninsured and medically indigent could be entirely eliminated if universal coverage became a reality in the United States. However, the assumption that such coverage would cover every individual residing in this country is unlikely. Instead, the effectiveness of universal coverage would need to be measured according to such factors as:

(1) what services would be covered by a universal insurance program (would it cover preventive and primary services as well as hospitalization? would it cover long term care, either nursing home or rehabilitation facility? etc.)?

(2) are there persons who are ineligible for universal coverage (i.e. undocumented persons)? and

(3) what would a universal plan do for those who are "under-insured" (those who have only very limited coverage)?

Direct subsidies from federal, state and local governments could be eliminated if a universal insurance program would take into account all of the questions raised above (and there are certainly additional questions). However, it is probably impossible to create a universal plan which would be so all-encompassing.

Simply stated, a federal program to provide universal health insurance could theoretically eliminate the need for public dollars. In practice, some percentage of current public dollars would need to remain in the system to cover those people and services outside of the federal program.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. I just want to make one very brief comment. I appreciate the quality of your testimony and the Children's Defense Fund work specifically on the impact on poor kids.

The community health clinics representatives were in my office on their annual visit a couple of weeks ago and made a really staggering comment. Of the $450 million that we allocate from the Federal level for community health clinics, $50 million goes for malpractice liability insurance premiums. And I think we need to begin to dissect those costs, to begin thinking about how that money could be reused, and any efforts you are aware of in any of the States to do that or any thoughts you may have on how to do that. Maybe we can wall off that situation before we are able to make systemic change. But it is a tragedy. As pressed as those community services are to provide preventive care, we have seen here that cost improvements could make such a difference for families in the cost of the system. The waste of 20 percent of those dollars is tragic. So I look forward to your comments on that.

Thank you.

Ms. HUGHES. Would you like me to comment now?

Mrs. JOHNSON. Very briefly. We are feeling the pressure of time.

Ms. HUGHES. There are a number of models available, but one of them, in Missouri, in particular, where providers who are serving low-income and Medicaid-covered patients are covered under the State plan. And there are national parallels to that. The physicians who are under contract with the Indian Health Service are covered under the Federal Tort Claim Act for purposes of malpractice.

I am happy to send to you and to submit for the record a variety of the models that have been introduced at the State and Federal level.

[The following was subsequently received:]

Children's Defense Fund
122 C Street, N.W.
Washington, D.C. 20001

Telephone (202) 628-8787

April 20, 1989

Hon. Fortney H. Stark
Subcommittee on Health
Committee on Ways and Means
1114 Longworth House Office Building
Washington, D.C. 20015

Dear Congressman Stark:

I want to thank you again for the opportunity to testify at the hearing on uninsuredness held on April 6. At that hearing I promised to send information on efforts to address the effects of high medical malpractice costs on providers of health care to the uninsured and underinsured.

Medical malpractice costs have increased exponentially in recent years, particularly for obstetrical care. A 1985 survey conducted by the American College of Obstetricians and Gynecologists (ACOG) found that more than 9 out of 10 members surveyed reported an increase in premiums during the previous two years, with an average increase equaling nearly $10,000. One in four physicians was confronted with an increase of $13,000 or more. While such increases are problematic for all physicians, they present the most severe burdens for those who serve large proportions of uninsured and publicly insured patients, for whom reimbursement rates are suppressed.

At the hearing Congresswoman Johnson mentioned one provider group that is experiencing an especially serious problem: community health centers. Malpractice costs have grown so much that they consumed approximately $50 million of the $500 million appropriated to community health centers in FY 1989, money that should be dedicated to health services.

The Children's Defense Fund recently completed a study for the Institute of Medicine of the National Academy of Sciences on the availability of obstetrical services at health centers. We found that at a time when demand for maternity care at health centers has increased (due to several factors including changing demographics, rising poverty and increases in uninsuredness), the ability of health centers to respond to that demand was severely undermined by escalating malpractice costs. Because high

malpractice drives down the value of other compensation that can be offered, health centers were not able to recruit or retain obstetricians and other maternity care providers. As a result, many health centers have long waiting periods for obstetrical care or else are being constrained from offering the services altogether.

These problems are found not only in community health centers but other clinic settings devoted to serving low income patients, such as Title V clinics as well as individual physicians who treat low income patients. As medical malpractice costs consume a greater share of already limited resources, low income women and their families have fewer and fewer services available to them.

During the past few years, several states have considered legislation related to malpractice, most of which has focused on tort reform. Only a few states have attempted to address the effects of high costs of medical malpractice on access to care specifically for low income women. Among those that have, the laws fall into two categories: initiatives to directly reduce the costs of medical malpractice insurance for providers who serve low income women; and initiatives to offer immunity to providers who treat low income women.

Initiatives to directly or indirectly reduce the costs of malpractice insurance

Two states, Missouri and Hawaii, have enacted legislation to assist providers meet malpractice premium costs when they treat low income women. The Missouri plan, which was enacted in July 1987, is probably the most promising. This law covers physicians who serve low income women under a newly created "state legal expense fund." In Hawaii, where a liability premium subsidy law was passed in July 1986, the state pays a portion of physicians' malpractice premium costs when the provider agrees to serve low income patients.

Initiatives to offer immunity to providers who treat low income women.

Two states, Virginia and Florida, have enacted legislation that offers immunity to physicians providing care under certain circumstances. The Virginia Good Samaritan Immunity Act provides immunity against malpractice claims for obstetrical care provided under emergency conditions without compensation. Both Virginia and Florida have adopted laws providing for no-fault liability for neurological birth-related injuries. The Virginia law includes language that requires participating physicians to participate in the development of a plan to address the health needs of indigent and Medicaid patients.

While it is encouraging to know that some states are aware of the effects of medical malpractice on access to care and are attempting to address the problem, the small number of states involved points to the need for national level attention to this issue. Ultimately, we must consider a major restructuring of the medical liability system to more rationally and effectively address medical malpractice when it occurs and to assist families in need of financial assistance when babies are born with special needs. Meanwhile, we should consider short-term remedies such as covering federally supported physicians, such as those in the National Health Service Corps, under the federal tort system.

Thank you again for the opportunity to testify and for your leadership.

Sincerely,

Dana Hughes, MPH, MS
Assistant Director for State
and Local Affairs

Chairman STARK. Thank you. I want to thank the panel very much for their contribution.

Our next panel consists of Dr. Jerome D. Gorman, representing the Physicians for a National Health Program; Richard Kronick, adjunct instructor, University of California, San Diego; and Peter Ferrara, a senior fellow of the Cato Institute, also associate professor of law at George Mason University.

Gentlemen, welcome to the committee. If you would like to summarize or expand on your prepared testimony in any way you are comfortable, please do so. We will start in the order that you are listed on the witness sheet.

Dr. Gorman, why don't you lead off.

STATEMENT OF JEROME D. GORMAN, M.D., RICHMOND, VA., ON BEHALF OF PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

Dr. GORMAN. Mr. Chairman, members and staff of the Subcommittee on Health, I am Jerome Gorman from Richmond, Va., where I am a physician in private practice and member of Physicians for a National Health Program. Thank you for inviting this presentation.

The physicians' proposal for a national health program was published in the January 12, 1989, issue of the New England Journal of Medicine. We support a program which would cover every American under a single comprehensive public insurance plan; establish and fund annual global operating budgets for hospitals and nursing homes; and fund capital costs through a separate budget.

We support a pluralistic approach to payment for physician services in any of three ways: fee-for-service with a negotiated but simplified and binding fee schedule; or negotiated salaries for physicians working in HMO's or employed by institutions with global operating budgets; or a choice to be paid for outpatient care, home medical care and physician services by capitation fees.

At least initially, funding would be from the same sources as present though all such funds would be transferred for deposit into a single public insurance pool. All disbursements would be made from this single pool. While this program would be federally mandated and eventually federally funded, it should be administered largely at the State and local level. We think it is desirable to test this program in statewide demonstration projects.

Considerable savings would be realized through consolidation and reduction of administrative overhead. A sharp decrease in the confusion and expense of multiple and repetitive accounting and billing procedures would be seen. Ongoing evaluation of the quality, effectiveness, safety and cost of medical and surgical treatments would be more complete and precise. Overall health planning would be enhanced. Medical care in rural and other underserved areas could be improved. Total health care costs would be more accurately monitored and spending limits established in a rational and fairer way. Health benefits would be consistent and predictable. A common and well-understood plan would free us from the chaotic nonsystem which is now so frustrating and so expensive. Americans would be protected from impoverishment or bankruptcy as a consequence of extraordinary medical expenses.

Insurance coverage would go with the patient at all times, whether young or old, student or employed, and when changing jobs, laid off work, disabled or retired. The privilege of patients to choose their physicians and hospitals—a traditional American value which is being seriously eroded—would be restored and maintained. It is known that copayments and deductibles are obstacles to the timely seeking of medical advice. We believe they should be eliminated because their removal would reduce the cost of more complex and expensive care often incurred when necessary care has been delayed. Copayments and deductibles are also a factor in high administrative costs. Under a standard public health insurance plan, employers—whether large or small—would have an equal footing in recruiting and retaining employees, either part-time or full time.

If health care costs were shifted to a single public insurance pool, we should expect the medical expense portion of other common insurance premiums would become unnecessary, thus lowering the cost of insurance for automobiles, homeowners and business liability, workers compensation and medical malpractice. These savings would be a favorable cost offset in the startup of a national health insurance program.

Americans have always shown broad support for a public agenda when it clearly serves the common good. We have done so in national defense, in education and in Social Security. Americans now seem ready to make universal health insurance a substantial concern of the public agenda.

My thanks again for the privilege of being here today.

[An attachment to the statement follows:]

The Case for a National Health Program

Steffie Woolhandler, M.D. and David U. Himmelstein, M.D.
for Physicians for a National Health Program

ALMOST EVERYONE AGREES that U.S. health care is in crisis. Conservatives tend to focus on the problem of skyrocketing health costs, while liberals concentrate on the 37 million Americans who are uninsured and often denied access to care. Both sides perceive the goals of cost control and improved access as irreconcilable. In this paper we review evidence that recent policy initiatives have exacerbated both problems and fostered bureaucratic domination of medical care. We argue that a national health program (NHP) incorporating key features of the Canadian system can simultaneously improve access, contain costs, and reverse the trend toward bureaucratization.

ACCESS IN THE EIGHTIES

The U.S. has the world's most technologically advanced and expensive health care system (1). Yet we are the only developed country other than South Africa which fails to guarantee all citizens access to medical care. For about 15 years, from the start-up of Medicaid and Medicare until the early 1980s, access to care, morbidity and mortality steadily improved, but costs soared. Between 1965 and 1980 the proportion of black women receiving early prenatal care increased 50 percent; the number of poor people who hadn't seen a physician in more than two years was halved; and the proportion of health care costs paid out-of-pocket declined from 52 percent to 28 percent (2). Meanwhile, the infant mortality rate fell 4.6 percent per year, and overall death rates decreased 21 percent (2,3). Unfortunately, during those 15 years real per capita health spending (corrected for inflation) doubled (2).

Since 1980 government and corporate policies have given priority to slowing cost increases. While these policies have yet to contain costs, their toll has already been high in terms of restrictions on care and inequalities in health. Decades of steady social and health progress have been halted, and in some cases, reversed.

Access to care is worst for the poor who are least likely to be insured and most in need of services. As the ranks of the poor have swelled (4,5), the number of people without private health insurance has increased dramatically - 47 percent between 1980 and 1985 (6). At the same time the proportion of poor families covered by Medicaid dropped from two thirds 10 years ago to 46 percent in 1985 (7) as the average income eligibility standard fell from 55 percent to 47 percent of the poverty line (8). As a consequence, the number of people without health insurance increased more than 40 percent between 1978 and 1986 to 37 million (9-11), including 9.5 million women of childbearing age (12). Fifty-four percent of the uninsured live in families headed by a full time worker (9), and 13.5 percent of all employed persons are uninsured (10). In 1984, 12 million workers earning less than $10,000 per year had no health insurance (9), nor did nearly one third of all students over the age of 18 and more than a third of the poor (10).

For those with some insurance, gaps in coverage, deductibles and co-payments may still impede access. For instance, 5 million women age 15-44 have private policies that don't cover maternity care (12). More than 20 million people have health insurance so inadequate that a major illness would cause financial

ruin (13). The elderly are particularly vulnerable since Medicare pays only 49 percent of their medical expenses (14), about the same proportion covered by insurance before Medicare's enactment. Today the elderly spend 15 percent of their income on health care, while low income elderly devote one quarter of total income to health care (15).

The number of under-insured, like the number of uninsured, is rising. Many employers anxious to limit benefit costs have reduced the comprehensiveness of private health insurance coverage and/or increased co-payments (16). Between 1985 and 1986 alone, the Medicare first day deductible for each hospitalization rose 23 percent, largely due to the DRG program, and over the past decade Medicare co-payments have risen 50 percent faster than the elderly's incomes (15). Many states have severely constrained Medicaid patients' choice of providers through "managed care" initiatives (17) - despite evidence from a large, randomized controlled trial that the health of the sick poor deteriorates in HMOs (18). Overall, for the first time in 50 years the proportion of health costs paid by insurance is declining, and the proportion paid out-of-pocket is rising (19).

These dry insurance statistics have very real and distressing human consequences - elderly patients foregoing vital medications because Medicare doesn't cover outpatient prescriptions; urgent surgery delayed until "insurance problems" can be cleared up; patients "lost to follow-up", at least partly because of the costs of care. A million families are denied care annually when they are sick because they cannot pay; 18 million more experience financial difficulty in obtaining care (12). Half of the families dropped from Medicaid in the early 1980s were left without insurance coverage (8). Their use of inpatient services dropped 71 percent, while their physician visits declined 38 percent (8). The most dramatic consequences of a "negative wallet biopsy" are seen in public hospital emergency rooms where thousands of uninsured patients are "dumped" each year from private hospitals unwilling to provide uncompensated care (21-23). Many of these transferred patients suffer shocking neglect.

Inadequate insurance coverage combined with funding cuts for public health programs has also undermined prevention. After decades of steady improvement, the proportion of pregnant women receiving prenatal care during the first trimester has stagnated since 1980 at 62 percent among blacks and 79 percent among whites (24). For teenagers early prenatal care rates are even lower (25,26). Among children less than 2 years old, 10 percent of blacks and 16 percent of hispanics haven't seen a doctor in more than a year (7). Forty percent of children age 1 to 4 years, and 80 percent of minority toddlers have not received a full series of vaccinations (27). Half of people with a diastolic blood pressure greater than 105 have not seen a doctor within the past year, and two-thirds of all hypertensives are poorly controlled (28), in many cases because they cannot afford medications (29). Half of all women have not had a breast exam within the past year, and one in five has not had a Pap test for at least five years (30) - often because of lack of health insurance (31). Nearly 20 percent of people with serious or chronic illnesses had no physician visit in 1986, and overall the proportion of people without a physician visit increased 70 percent from 1982 to 1986 (20). Forty-three million Americans could identify no regular source of care in 1986, an increase of 65 percent over 1982 (20).

These barriers to access and inadequacies in prevention almost certainly contribute to the United States' poor record on infant mortality, life expectancy and other measures of health status. For instance, a recent 118 percent increase in reported measles cases signals that falling immunization rates have begun to take their toll (32). Despite our vast wealth, the U.S. infant mortality rate ranks only 17th lowest among nations (24,33), and

the rapid improvements of the previous decade have stalled during the 1980s (2,7,24). High postneonatal and maternal mortality rates for blacks have not fallen over the past five years, after decades of steady decline (2,7,24). This data for blacks must illustrate socioeconomic as well as racial disparities, since vital statistics data are not routinely categorized by income or social class (34). Overall U.S. death rates are higher than in many other affluent countries (35), and have commenced an almost unprecedented upswing (19).

Much of the illness among minorities and the poor is due to medically preventable and treatable conditions (36-38). Most of the excess mortality among blacks is due to heart disease, strokes, cancer, diabetes, and infant mortality - things physicians can do something about. But only if the patients get to their offices.

To summarize: about one-quarter of Americans are inadequately insured, and the number has been rising; they are often denied care or are reticent in seeking it because they cannot pay; their health is worse and their death rates higher than the affluent and well insured; and our national health statistics reflect the deepening access crisis. In effect we are rationing health and health care based on ability to pay. Some form of rationing would be necessary if health resources were in short supply. But the U.S. faces a growing surplus of hospital beds and physicians (39,40). In effect, health policy has focused on "rationing the surplus", an exercise which might be comical if its consequences were less dire.

THE COST CRISIS AND THE BUREAUCRATIC SQUEEZE

Health policy in the 1980s has been characterized by a virtual obsession with cost control. An exposition of the resulting welter of programs, strategies, and incentives is beyond the scope of this paper. But a few key trends are discernible.

First, costs have not been contained (41). Expressed in constant dollars (ie. adjusted for the consumer price index), health expenditures are rising more rapidly during the 1980s than they did in the late 1970s (19,41-43). Costs continue to spiral upwards despite declining hospital occupancy rates, cuts in federal and state programs, increasing insurance co-payments, and rising HMO enrollments.

Second, most cost containment strategies have constrained clinical services through administrative limitations or financial barriers. However, the bureaucratic apparatus needed to erect, maintain and police these disincentives to care is itself extremely costly (44). Thus the Medicare DRG program has forced hospitals to spend billions on new billing computers, DRG coordinators, and other administrative appurtenances needed to assure financial survival (45,46). The risk of undercare inherent in DRGs has spawned an army of vigilant overseers (PROs), whose demands for copies of medical records has forced hospitals to spend as much as $75 million annually on photocopying alone (47). Similarly, HMOs spend large sums enforcing disincentives to care (and excluding non-members entirely), resulting in administrative costs approximating those in fee-for-service practice (48, and Willis D, Brudevold C: personal communication). By 1983 bureaucratic costs accounted for 22 percent of U.S. health spending (44), a proportion which continues to increase (49). The number of health administrators is rising three times faster than the number of physicians or other health care workers (2,50-53). In 1985 health insurance overhead alone consumed $106 per capita, as much as research, public health programs and new health facility construction combined (41).

Third, recent policies have provided incentives for health institutions to act in a more "business-like" way. Unfortunately, sound and compassionate clinical decisions sometimes lose money for a hospital or HMO. Policies that encourage a more "business-like" approach reward institutions willing to bend clinical practice to financial exigency, and thus assure administrative intrusion into clinical decision making (54-56). In this context, each institution pursuing its own "rational" interests leads to irrationality in the system as a whole. Thus research has linked increasing competition with higher hospital costs (57), longer lengths of stay for surgical procedures (58), and higher death rates (59). The fiscal laxity of the past has given way to intensive efforts by hospitals and HMOs to streamline their operations, and especially to monitor and regulate medical practice. Hospitals and HMOs are identifying high cost and low profit physicians, patients, and services. Dumping these money losers (eg. sicker patients likely to have longer lengths of stay, and the more experienced surgeons who tend to care for them (60,61)), profits individual hospitals and HMOs, but worsens the overall quality of care (62) and raises system-wide costs.

The resulting spectacle of bureaucracy gone wild occasionally reaches epic, almost comedic, proportions. Some HMOs have reportedly placed their enrollment offices on the upper floors of buildings without elevators to discourage the infirm. In our hospital, a zealous administrator fearing loss of reimbursement outlawed the occasional practice of allowing an inpatient to enjoy a holiday dinner at home with family. He sacrificed his Thanksgiving patrolling the hospital lobby, and turned back a single patient: a young woman hospitalized for anorexia nervosa.

Incentives meant to increase competition have also resulted in a sharp increase in advertising. Aggressive marketing by an insurer, HMO or hospital may increase its market share, but the costs of TV commercials, full-page newspaper ads, and "free" health-spa memberships (offered by one Boston area HMO), must ultimately be subtracted from the money available for clinical services.

The failure of cost control to date suggests that any savings from reduced clinical care have been more than offset by growth in the bureaucracy needed to "beat" and police the system. Apparently, achieving cost containment through further pursuit of current strategies will require ever more stringent financial and administrative disincentives to care, and ever greater bureaucratic domination of medical practice.

JOINING THE CANADIAN CLUB

If the failings of our health policies are widely acknowledged, the feasibility of solutions is as widely disputed. The extension of access seems to conflict with the imperatives of cost containment. Yet experience in other countries suggests that universal access to comprehensive care can be achieved at acceptable cost. Canada is a particularly useful example. Patients there face few financial barriers to care (63,64); costs are moderate (65,66); and the quality of care is comparable to that in the U.S. Moreover, until the mid 1960s the health care systems of the U.S. and Canada were quite similar.

Shortly after the passage of the U.S. Medicare and Medicaid programs, the Canadian Parliament enacted legislation offering federal matching funds for provincial health insurance plans meeting the following criteria (67):

1- Universal coverage "that does not impede . . . whether by charges made to insured persons, or otherwise; reasonable access."
2- Portability of benefits from province to province.
3- Insurance for all medically necessary services.
4- A publicly administered non-profit program.

The resulting provincial programs pay for about 90% of all hospital and medical care. Private insurance has little role since by law it can only cover services not covered by the public plans (eg. some long term and dental care). Funding comes principally from progressive taxes, though some provinces charge mandatory premiums, which really amount to a regressive form of taxation. Thus all Canadians are covered for essentially all acute care services, and payments for these services come from a single government insurance fund in each province.

Most Canadian hospitals are private, not-for-profit institutions. Each hospital receives an annual global (lump sum) budget to cover all operating expenses. Capital funds (ie. for new buildings or machines) also come from the insurance fund, but are allocated separately based on hospital requests and provincial health planning goals (68). Patients are billed only for luxury items such as elective private rooms.

Most Canadian physicians are paid fee-for-service based on fee schedules negotiated between the provincial governments and medical societies. A minority are employed in salaried positions. Physicians can bill only for their personal services, ie. they cannot be reimbursed for the costs of CT scanners or other expensive machinery in their offices, nor for the work of physicians assistants or other physician extenders. A recent law has essentially banned "balance" billing (69); physicians must accept the fees from the insurance fund as payment in full. Physicians may affiliate with any hospital willing to grant them privileges.

The Canadian system has proven extremely popular with patients (67), who have free choice of providers with virtually no out-of-pocket costs. Access to care for the poor improved dramatically with the institution of universal coverage (63,64). Most measures of health status are at least as good as the comparable U.S. figures.

Cost increases have been modest. While the U.S. and Canada devoted similar proportions of GNP to health care in the 1960s, by 1985 health care accounted for only 8.6 percent of GNP in Canada and 10.6 percent in the U.S. (19,66).

Medicine remains a desirable and prestigious profession in Canada. Indeed there are many more applicants per medical school slot than in the U.S. (4.7 vs 1.8) (70,71). Physicians have objected, often strenuously, to the elimination of balance billing and other constraints on fees. However, physician incomes are high (4.8 times the average industrial wage, similar to the U.S. figure), and income differentials between primary care and procedure oriented specialties are relatively small. There is less bureaucratic intervention in clinical practice than in the U.S., and billing is considerably simpler. Fewer than 400 physicians chose to emigrate in 1985 (72).

The Canadian approach has encountered several problems. Some providers argue that constraints on capital spending have resulted in inappropriate rationing of high technology equipment and services. Certainly expensive technologies such as CT and MRI scanners have diffused more slowly than in the U.S., and fewer coronary artery bypass operations are performed (though it is unclear whether optimal rates are closer to the Canadian or U.S. figures). But the lengthy queues for services that have plagued

the British National Health Service are not a feature of the Canadian NHP.

Fee-for-service reimbursement encourages excessive interventions, and generates pressure for cost increases from physicians and regulation from government. In the face of rigid fee controls physician visits and referrals have increased. Government has responded by limiting the total pool of money available for physician payment, and some provinces have placed caps on physicians' incomes.

The geographic maldistribution of physicians continues. In response some provinces have offered fee premiums for physicians in underserved rural areas, while British Columbia has virtually banned the establishment of new practices in over-doctored areas.

Though some provinces have introduced innovative long term care programs (73), the provision of these services remains uneven. Additional problems include insufficient preventive activities, which are reimbursed but scarcely encouraged, and the failure of the Canadian system to deploy physicians' assistants, nurse practitioners and other non-physician providers.

While a health care system cannot be transplanted from one society to another, the U.S. can learn much from Canada (74). Coverage of all provincial residents under a single program has saved billions of dollars annually by greatly simplifying billing and administration (44). The monopsony payment system also aids in cost containment by facilitating enforcement of overall spending limits (75). Public administration has proven much more efficient than private insurers. Insurance overhead consumes only 2.5 percent of funds, similar to the U.S. Medicare program but less than a third the percentage taken by private U.S. insurance firms (44).

Canada handles hospital capital allocation more efficiently than the U.S. In the U.S., capital payments are folded in with operating reimbursement, creating undesirable economic incentives. Coupling operating and capital budgets encourages undercare in prospective payment systems like DRGs since money not spent on patient care can be used for institutional expansion. Conversely, such combined budgets encourage excessive interventions in fee for service settings, since the higher charges mean higher capital payment. Combining operating and capital payments under either fee-for-service or prospective reimbursement undermines health planning since wealthy hospitals can expand while financially strapped institutions cannot - regardless of health needs. In contrast, the Canadian system of capital payments rewards neither skimping on care nor excessive intervention. It allows funds for expansion and modernization to be directed to areas of greatest need, preventing overbedding and encouraging the regionalization of services (68).

The Canadian experience also suggests that detailed administrative oversight of day-to-day clinical practice is not necessary if financial incentives for both insufficient and excessive intervention are minimized. Indeed, mounting costs in the U.S. despite increasingly stringent administrative control of medical practice may indicate that such oversight costs as much as it saves.

In summary, Canada's NHP has virtually minimized financial barriers to care at acceptable costs, while maintaining clinical standards on a par with the U.S. These apparently conflicting goals have been reconciled through a system which cuts administrative waste and cost, allows the enforcement of systemwide spending limits, and facilitates health planning.

The adoption of similar measures in the United States is fraught with political difficulty. The insurance industry will vigorously oppose the elimination of most billing, and the substitution of public for private administration. Similarly, some hospital administrators, particularly at financially successful institutions, may oppose global budgeting (which would eliminate many administrative jobs) and stringent health planning. However, about two-thirds of the American people have supported a universal, comprehensive, publicly funded and administered NHP in every opinion poll over the past twenty years (76,77). The same proportion voted in favor of the statewide NHP referendum in Massachusetts in 1986, a major impetus to that state's recently passed (though seriously flawed (78)) universal health insurance bill. Employers whose health insurance costs have been skyrocketing also have strong reason to favor a Canadian-style NHP which would sharply cut employee benefit costs. Finally, many physicians may find a public service oriented NHP preferable to the status quo.

CONCLUSIONS

In the U.S., recent health policies have restricted access and fostered bureaucratic dominance of clinical practice. Patients are being denied health care in the face of a growing surplus of health resources. Meanwhile, costs continue to escalate despite, or perhaps because of, the growing bureaucracy charged with restricting care.

We believe that it is possible to assure all Americans free access to high quality care at acceptable cost. However, this will require an NHP which greatly streamlines administration, establishes a single source of payment for virtually all services, and encourages health planning. Such a National Health Program is technically feasible but politically difficult. Without it we will continue to wrestle with an insoluble contradiction between cost and access.

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Chairman STARK. Thank you very much, Doctor.
Mr. Kronick.

STATEMENT OF RICHARD KRONICK, HEALTH POLICY ANALYST, DEPARTMENT OF COMMUNITY AND FAMILY MEDICINE, UNIVERSITY OF CALIFORNIA, SAN DIEGO

Mr. KRONICK. Good morning, Mr. Chairman and members of the committee. My name is Richard Kronick. I am a health policy analyst in the school of medicine at the University of California, San Diego. I would like to thank you very much for the opportunity to testify this morning.

I will cover the highlights of a plan to achieve universal health insurance that I designed last year with Alain Enthoven, who is a health economist at Stanford University. The proposal was published recently in the New England Journal of Medicine, and details are available there.

As you have heard repeatedly this morning, our health care economy is a paradox of excess and deprivation. We spend over 11.5 percent of our gross national product on health care, far more than any other country. And the cost problem has gotten worse. In the 1980's, real per capita health care costs have grown at 4.6 percent per year, which is higher than the 4 percent rate of growth in the 1970's. These growing expenditures are adding to public sector deficits, which I certainly do not need to tell you, and threatening the solvency of some industrial companies creating hardships for many people. At the same time, we have the scandal of 35 million people without any health insurance at all. So we spend too much for some and too little for others.

I think there is a lot of agreement on this indictment, and the question is what to do about it.

Our proposal addresses both the problems of deprivation and excess. To get everybody insured, we propose that everyone not covered by Medicare or Medicaid be enabled to buy affordable coverage, either through their employers or through a public sponsor. To attack the excess, the problem of spending too much, we propose a strategy of managed competition in which sponsors, such as large employers, HCFA, and the State level public sponsors that I will talk about in a second, in which these sponsors contract with competing health plans and manage a process of cost conscious consumer choice that rewards providers who deliver high quality care economically.

The key here is to try to create an environment in which providers, primarily doctors and hospitals, see it as in their interest to figure out what works, to adopt the techniques that work, to abandon the techniques that do not, and to try to match the resources that are available to the health needs of the population. And that is a very different environment from the environment that providers function under today.

Our proposal has four key elements; let me first mention them and then briefly elaborate on each. First, a requirement that employers offer group coverage and pay 80 percent of the cost to all their full-time employees, very similar to proposals that have been considered here.

Second, the creation of State level public sponsors that would function much like an employer on behalf of those who are not covered under the employer mandate. That is, these public sponsors would contract with health plans, manage the enrollment process, and make subsidies available to people who are not covered by their employer to part-time employees, to self-employed people, and to the unemployed.

Third, a limitation on the amount of tax-free employer contributions to health insurance.

And, fourth, a "pay or play"—one might call it a contribution, but by the Darman rule certainly a duck—tax on the earnings of part-time workers and on the income of self-employed people who are not covered by their spouse.

Let me briefly discuss these four points. The employer mandate would require employers to contract with a choice of qualified health plans and to contribute 80 percent of the average cost for full-time workers and their dependents. We suggest that workers employed for more than 25 hours per week be considered full time, but that number, like many of these numbers, is a "tunable dial".

Second, we propose the creation of State level public sponsors we have in mind here institutions that are much like the Group Insurance Commission in Massachusetts or PERS in California that currently contract for health care on behalf of State employees. And what we imagine is expanding that function to cover people who are not covered by their own employer. One advantage of having these public sponsor agencies is that they also provide a vehicle for small- and medium-sized employers to take advantage of the advantages of managed competition. Small- and medium-sized employers cannot do a good job, because of their size, of finding their way in a competitive market. It is hard work, and I will talk about that briefly below.

The third element is a limitation on the tax-free employer contribution. Right now when employers contribute to an employee's health care coverage, all of that contribution is tax free. We propose limiting this to the 80 percent that is required of employers to contribute. So we say to employers: You must contribute 80 percent of the average cost of a qualified health plan. That 80 percent is tax free. And on top of that, any additional contributions will be taxable income. And there are two reasons for this part of the proposal. The first is to raise money. The Congressional Budget Office estimates that in 1988 this would have raised about $11 billion, assuming that the family premium was $2,400 a year, which seems like a reasonable assumption. That $11 billion is part of the money that the public sponsor needs to provide subsidies to the part-time employee, the self-employed and the unemployed.

Now, certainly those of us from whom the $11 billion is raised will not like it, or many of us will not like it. But one response is that there is a very strong equity argument here. Those people who have any idea, if you ask them, what are the 2 largest Government expenditures for health care, are likely to say Medicare and Medicaid. The truth is at the Federal level, at least, the largest expenditure is Medicare and the second largest is the tax expenditure, and that tax expenditure goes mostly to the relatively well-off members

of society. There is a strong equity argument to use some of it on behalf of people who do not have employer contributions.

The second reason for the tax limitation is to create a situation in which employees are faced with cost conscious choices among health plans. Anybody who has been involved in labor negotiations will tell you that the effect of the tax exemption on the employer contribution philosophy is to increase—once the total amount of compensation is decided upon to increase the part of it that is going to health care and decrease the part that is going to wages or other fringe benefits. And what that means is that most employees in our society still are not required to pay more money if they choose a more expensive health plan. And as long as that is the case, there is no chance that a "competitive", model is going to work.

Chairman STARK. You are an economist, are you not?

Mr. KRONICK. Yes, sir.

Chairman STARK. How far can you go? I mean, there has got to be marginal returns on that. How much health insurance do you want? You are talking about the tax cap. Do you think there is just a completely inelastic demand for health care by an employee?

Mr. KRONICK. No. I think, in fact, that the evidence is that when employees are faced with choices among health plans, they gravitate towards the less expensive. And the problem is that many employees——

Chairman STARK. Well, then, let us give it to them free. I mean, there is only so much they can sop up.

Nobody wants to go to the hospital or get sick. So if you have got a plan that covers both illnesses, what more do you want?

Mr. KRONICK. Right. And what you want is for doctors and hospitals to be rewarded if they figure out how to keep people out of the hospital.

Chairman STARK. So in your home town, they belong to Kaiser. You have got everything: excellent care, best quality, absolutely everything is free.

Mr. KRONICK. That is right.

Chairman STARK. How much more is there?

Mr. KRONICK. That is fine. Nobody needs more. The problem is that in many places there is no incentive, or little incentive, for many employees to join Kaiser, or an organization like Kaiser. And doctors and hospitals still do much—there is a lot of uncertainty in medical care. You hear that all the time. And how do you resolve the uncertainty if you are a provider?

Well, you know, you try to do what is right, but it is natural that you are also going to do what might make you more money. And in the current health care economy, what makes you more money generally is doing more. What we need is a health care economy in which those incentives are changed.

Chairman STARK. I have no quarrel. I am just saying that the average American does not think that way. The sophisticated analysts of the program understand that, but the average worker says: I have got health insurance. The average young, healthy worker does not know what is in the benefit plan generally, and it is a matter of indifference. If you offer them an extra buck an hour, they will take the buck an hour.

Mr. KRONICK. I think that if you look at the Federal Employees Health Benefits plan, which has a lot of problems, some of which are trying to be addressed, people gravitate towards the lower cost plans. And one of the problems is that the lower cost plans may well be lower cost because they have got healthier people and not because they are more efficient. That is a very major problem that needs to get dealt with in a context of managed competition. That is part of why small- and medium-sized employers cannot do it very well.

But to the extent that lower cost health plans—and I think Kaiser is a good example—are lower cost because they are more efficient, that is going to deal with the cost problem, or at least that kind of movement is going to deal with the cost problem.

Let me just say that the fourth feature of the plan is to raise some of the money that is needed for these public sponsors from the people who would benefit. That is, self-employed people could go to a public sponsor and say: I would like to choose among the health plans that you have contracted with, and get that 80 percent subsidy. They should contrive to pay that premium subsidy, and they would do that through the Tax Code. Similarly, for part-time employed people who are employed in multiple part-time jobs.

This idea is similar to the Taft-Hartley trust here. The employer, instead of contributing to a Taft-Hartley union trust, is contributing toward the public sponsor, basically.

CBO has estimated the effects of our plan on coverage and cost on public sector budgets. The details are in my written testimony the paper and also available in the New England Journal of Medicine article, and they have estimated that the program would be deficit neutral; that the revenues that are raised from these additional taxes would be equal to the revenues that the Federal Government would need for the various subsidies.

Let me just talk briefly about why we think this might work. It would certainly get 35 million people insured. There is less certainty about whether it would constrain cost growth. Certainly, competition has gotten a bad name in the 1980's. I think a lot of people may say, well, we have tried competition and it is not working.

I would certainly agree that whatever we have tried is not working, but it is not competition. It is still true that most employees do not have to pay more money if they choose a more expensive system of care. That would be one basic requirement for competition and a big part of that reason is the tax treatment of health insurance, which encourages employers to put too much in.

The second requirement for competition to work I alluded to briefly above—you cannot just contract with a bunch of health plans and tell employees: You figure it out. The sponsor needs to give a lot of help to employees, and there needs to be a strong management effort on the part of the sponsors. Some of this effort is information gathering and dissemination—for example, surveying employees to find out what their experiences are; certainly looking at people who disenroll from health plans to find out if they are disenrolling because they were sick and they did not get good health care; and moving towards risk adjustments of contributions in which health plans that take care of more sick people get more sponsor contribution, and in which health care plans that take care

of fewer sick people get a smaller contribution. We certainly do not want to put health plans out of business if they do a good job of taking care of AIDS and of people with heart disease.

I have got much more, but I am well out of time.

[The statement of Mr. Kronick follows:]

STATEMENT OF RICHARD KRONICK

Good morning. My name is Richard Kronick. I am a health policy analyst in the Department of Community and Family Medicine at the University of California, San Diego. This morning I will cover the highlights of a plan to achieve universal health insurance that I designed last year with Alain Enthoven, who is a health economist at Stanford University. This plan was published in the New England Journal of Medicine on January 5 and January 12, and details are available there.

Let me mention at the start that this plan is not the work of fuzzy-headed academics: before moving to California I spent four years in Massachusetts state government -- two years working on policy initiatives increasing access to care, including the early stages of the 'Health Care for All' legislation that was passed last spring, and two years in the Medicaid program managing policy and reimbursement activities. So I have a strong sense of the realities of the political process (or at least one of them) and of the operational strengths and weaknesses of state government. The proposal I will describe today has been designed with these considerations in mind.

Statement of the Problems

Our health care economy is a paradox of excess and deprivation. We spend about 11.5% of our gross national product on health care, much more than any other country. And where other countries have stabilized the share of their GNP that is spent on health, ours has accelerated in recent years. These growing expenditures are adding greatly to deficits in the public sector, threatening the solvency of some industrial companies, and creating heavy burdens for many people.

At the same time, roughly 35 million Americans have no financial protection from the expenses of medical care. Our present system of financing health care systematically denies coverage to many who need it most. Health insurers want to insure those who are the least likely to need medical care and to protect themselves and their policy holders from the costs associated with the care of the very sick.

The present system of financing health care in the United States is unfair. It provides most people -- those who are regularly employed by a medium sized or large employer -- with coverage either at no cost or at prices subsidized by the employer and the tax system. But the system denies the opportunity of coverage to millions of others for no good reason -- to seasonal and part-time employees, self-employed persons, widows, divorcees, early retirees, the unemployed, and others whose employers choose not to provide health care coverage. Viewed another way, when the uninsured are seriously ill (and most expenses are for seriously ill patients), taxpayers, insured persons, or both end up paying for most of their care. Voluntarily or involuntarily, some people are taking a free ride. Those who can do so ought to contribute their fair share to their coverage and be insured.

The present system is wasteful in many respects. We have spent little on evaluating medical technology, and there is much uncertainty about its efficacy. Much care appears to be of unproved value. There is considerable duplication and excess capacity in our medical facilities.

The U.S. health care economy is inflationary. It is still dominated by fee-for-service payment of doctors and hospitals by third-party intermediaries with open-ended sources of finance. There is no total budget set in advance within which providers must manage the care of their patients. For the most part, there is no incentive to find and use medical practices that produce the same health outcome at less cost. And this method of payment leaves insured consumers largely unaware of the costs of the services they receive.

Health maintenance organizations and preferred provider organizations now cover more than 60 million Americans. Such plans have the potential to create serious cost consciousness among consumers and providers. But they will not achieve it as long as potential subscribers do not have to pay the full extra cost themselves when they choose a more costly plan.

The employers of most insured people offer their employees a traditional insurance scheme by which all or most of their medical expenses are reimbursed after the payment of a deductible. If employers offer a less costly managed care plan, they often offer to pay its premium in full, as long as it does not exceed that of the traditional plan. Thus, the managed care plan has little or no incentive to reduce its price or improve its efficiency, because the employee making the choice sees little or no financial reward for choosing it. The tax-free status of employer contributions to health insurance encourages employers to contribute too much to health insurance and thus prevents employees from making cost conscious choices.

Some employers offer a fixed-dollar contribution and a cost-conscious choice of plan. In such cases, the managed care plan is motivated to reduce its price to attract subscribers. But even then, the Internal Revenue Code permits employees to characterize their premium contributions as nontaxable employer contributions and thus make the payment with pretax dollars. The effect is that if an employee chooses a health plan that is more rather than less costly, the government is likely to be paying about one-third of the difference in cost in the form of tax relief. As a result, the employee's cost consciousness is attenuated, and the health plan has less need to cut its price to attract subscribers. In any case, health plans have little or no incentive to

improve their efficiency in order to serve a few cost-conscious customers if most of their customers are not cost conscious; such plans need only shift costs from the former to the latter.

Moreover, most such 'managed care' plans are really little more than traditional insurance arrangements that deal with physicians on an arms-length basis. It is unlikely that they will be able to achieve economical organization and delivery of care without obtaining the support of physicians and their commitment to that goal.

For all these reasons, our present system of health care does not reflect American values. We cherish efficiency and fairness, but we have a system that is neither efficient nor fair. Very few Americans believe that other Americans should be deprived of needed care or subjected to extreme financial hardship because of an inability to pay. There is widespread public outrage when a hospital turns away a delivering mother or an injured person for this reason. Congress has passed laws to punish hospitals that do this. But we have failed as a society to create institutions that assure all persons of the opportunity to obtain needed care, when they need it and without an excessive financial burden.

Although some might disagree on the particulars of this indictment, most would agree with the general outline. We use too many resources for the medical care of some, and not enough for the medical care of others. What should we do about it?

A Universal Health Insurance Plan Based on Managed Competition with Mixed Public and Private Sponsorship

To remedy the deprivation, we propose that everyone not covered by Medicare, Medicaid, or some other public program be enabled to buy affordable coverage, either through their employers or though a 'public sponsor'. To attack the excess, we propose a strategy of managed competition in which collective agents, called sponsors, such as the Health Care Financing Administration and large employers, contract with competing health plans and managed a process of informed cost-conscious consumer choice that rewards providers who deliver high-quality care economically.

Our proposal has four key elements:

first, a mandate that employers provide coverage to full time employees;

second, the creation of state-level public sponsor agencies that would function much like the health benefits operation of a large employer (that is, contract with health plans, manage an enrollment process, administer subsidies, and more generally manage competition among health plans) on behalf of people not included in the employer mandate -- e.g., the self-employed, the part-time employed, the unemployed. In addition, the public sponsor would function as a health insurance broker for small and medium sized businesses, giving them access to the advantages of 'managed competition' and large group purchasing power.

third, a limitation on the amount of tax free employer contribution to health insurance;

fourth, a 'pay or play' tax on the earnings of part-time workers. Employers could choose to provide health benefits to part-time workers; if they choose not to, as we suspect most would, the employer would pay a tax on their earnings.

The first element -- an employer mandate -- would require employers to offer their full time employees a choice of qualified health plans. We endorse a proposal similar to that proposed in the last session in a bill introduced by Senator Kennedy and Congressman Waxman. Employers would be required to pay 80% of the cost of the average qualified health plan for employees and their dependents. Employees could not waive coverage for themselves, and could waive coverage for dependents only if the dependents were covered by their spouse.

The second element is the creation of state level public sponsors. These agencies, like employers, would offer a choice of qualified health plans to all people who were not covered by an employer based plan. The public sponsors, like employers, would pay 80% of the average cost of the qualified health plans with which they had contracted in a given geographic area; the individual or family purchasing coverage from the Public Sponsor would pay the difference between the 80% subsidy and the cost of the health plan chosen.

Public Sponsors would offer to act as brokers for employers who wished to obtain coverage through these agencies. Small employers and even many medium-sized employers are not large enough to manage competition among health plans effectively. Moreover, small employers that buy insurance on their own are forced to pay higher rates. A public sponsor could combine these risks and achieve economies of scale. States could achieve economies in administration as well as greater bargaining power

with the health plans by assigning the Public Sponsor responsibility to the agencies that already buy coverage for state employees.

Public Sponsors would also administer two additional subsidies. First, the requirement to pay, on average, 20% of the cost of a health plan will keep many low income people from being covered. The public sponsor would waive this 20% payment requirement for those below 100% of poverty, and phase it in on a sliding fee scale for those between 100% and 150% of poverty. (We are not, at this point, proposing any changes in the Medicaid program. I'll discuss this more below.)

Second, Public Sponsors would administer a subsidy to small businesses. The employer mandate will have a greater effect on small businesses than larger ones, since small businesses are less likely to provide coverage currently. In order to cushion this impact, and minimize economic dislocation, we propose that small businesses (fewer than 25 employees) that arrange coverage through the Public Sponsor would be required to pay no more than 8% of their payroll for health benefits. That is, if the 80% contribution that is required of employers is more than 8% of payroll, small business would pay only the 8% of payroll and the Public Sponsor would pay the rest.

The third element -- the tax cap -- would limit the amount of tax free employer contribution to 80% of the average cost of a qualified health plan -- that is, the amount that employers are required to contribute. Our plan would require employers to contribute 80%, and would provide that any contributions above that amount are taxable income to the employee.

This is a key element of the plan for two reasons. First, it is a necessary ingredient to create cost-consciousness in the choice of plan for consumers. As anyone who has ever been involved in labor negotiations will tell you, the existing tax rules result in a greater allocation of total compensation to health benefits and less to cash income than would occur with a different tax treatment. The first requirement of 'managed competition' is that consumers should be faced with the cost difference among plans when choosing a provider group, and this principle is unlikely to be met as long as the entire amount of employer contribution is tax free.

The second reason why the tax cap is a key element of our plan is that it raises some of the revenues needed for the Public Sponsor to offer the 80% subsidy to individuals and families not covered by their employer. The Congressional Budget Office has estimated that the tax cap would raise approximately $11 billion if the average price of a qualified health plan was $2400 per year.

Those of us who will be paying this extra $11 billion in taxes may be unhappy about this, but there is an extremely strong equity argument to be made here. The statement typically made about Federal government health care spending is that Medicare and Medicaid are the two largest programs. But the tax expenditure for employer provided health benefits is significantly larger than the Federal share of Medicaid. And the primary beneficiaries of this expenditure are the relatively better off members of our society. Surely it makes sense to redirect a small portion of this expenditure to people with greater need.

The fourth element of our plan -- the play or pay payroll tax -- would require employers to pay an 8% tax on the first $22,500 of earnings of part time workers to whom they were not providing health benefits. For self-employed people who were not covered by the employment based policy of their spouse, this tax would be collected through the income tax system. This tax is important for two reasons. First, it would raise a portion of the revenue to support the Public Sponsor subsidies directly from people who would benefit from these subsidies. Second, it would reduce the otherwise strong incentives for employers to reduce a worker's hours from full-time to part-time status. That is, if we tell employers that they must pay 80% of the health benefits cost for full-time workers but that they need pay nothing for part-time workers, there will be a strong incentive to create more part-time work. The tax on the wages of part-time workers will reduce this incentive.

Summary of the Four Key Elements

These four elements of our plan are needed in combination to create a system of universal health insurance designed to promote quality and economy:

The employer mandate is needed to prevent employers from dumping their employees on the Public Sponsors. But alone,

it leaves out 12 million people not full-time employed and their dependents;

without the 'pay or play tax' it leaves a strong incentive for employers to attempt to escape the mandate by hiring 24 hour per week employees;

without the tax cap, it doesn't address the cost problem.

Public Sponsors are needed to receive revenues and translate them into health insurance subsidies for those otherwise uninsured, to develop and demonstrate

strategies of managed competition, and to make the benefits of managed competition available to small and medium sized employers. But alone,

they can't make the total system cost-effective;

they need a cost-effective private sector to be able to afford to do the job;

they can't cover the uninsured without a revenue source.

Tax Cap -- i.e., the limit on tax-free employer contributions, is needed to make people cost-conscious and to raise funds to subsidize those presently uninsured. But alone,

it would attack internal cross subsidies to bad debt-free care, worsening the problem of the uninsured;

it would not channel the revenues into health insurance.

'Pay or Play Payroll Tax' -- i.e., employers must pay an 8% payroll tax on all part-time employees not provided health insurance by the employer -- is needed to spread the financing burden equitably over all employment and to reduce the incentive to escape the mandate. But alone,

it doesn't raise enough revenue

it needs a broker agency (the public sponsors) to translate the funds into health insurance purchases;

it doesn't create cost-consciousness.

Federal-State Cost Sharing

In our proposal the federal government would reimburse the state level Public Sponsor agencies 50% of the expected average cost of a qualified health plan for each individual/family that bought coverage from them. This is similar to Medicaid, with the major change that instead of simply paying half of whatever the state spends, the federal government would compute a national average cost, use price level adjusters to compute the 'expected' cost in each state, and pay half the 'expected' cost instead of half of the average cost. Using this sort of system the federal government will not be subsidizing the expensive practice patterns that are the norm in some states, and will reward states with relatively more economical practice patterns. As with Medicaid, this formula could certainly be changed to provide a larger subsidy to states with greater need.

States would pay the difference between the 50% federal subsidy of 'expected' cost and the 80% subsidy that the state level public sponsor would be required to offer to otherwise unsponsored individuals and families. States would be expected to finance their portion of the bill in large part from funds already being spent for uncompensated care.

Relationship to Medicare and Medicaid

We propose no initial change in Medicare and Medicaid. The public sponsors would have enough work to accomplish the objectives set out thus far. However, once this program was operating successfully, there would be opportunities to sue the capabilities of the public sponsors to assist the Medicare and Medicaid programs. For example, Mediciad programs should consider contracting with the public sponsors to provide coverage for families on welfare, in order to ease the transition from welfare to work. The existence of the public sponsor would mitigate the work disincentives associated with losing eligibility for Medicaid because of an extra dollar earned, and a Medicaid-public sponsor agreement would mitigate this disincentive further. The existence of nearly universal coverage through the public sponsor should greatly reduce the number of people who 'spend down' into Medicaid.

Managed Competition, Technology Assessment, and Management of Outcomes

Public and private sponsors will have to work hard to make managed competition work. Simply requiring consumers to pay more if they choose a more expensive health plan will not automatically result in the type of market in which providers will find it in their interest to figure out how to deliver high quality, economical care.

Sponsors must continuously monitor and adjust the market to overcome its tendencies to failure. Some things they should do are relatively easy: they should monitor disenrollment from health plans and take corrective action if a health plan is 'extruding' its sickest members. They should standardize benefit coverages, so that when consumers are comparing across plans they are making a relatively clean price comparison, and not one contaminated with benefit differences as well. They should, as

most do now (although Medicare and many Medicaid agencies do not) manage enrollment themselves, and not give health plans the opportunity to discourage bad risks from enrolling.

Other actions that sponsors should take require more effort, but are equally important. First, they should develop risk-adjusted contribution systems. That is, sponsors should make larger contributions (more than 80% of average) to health plans that have a greater than average number of members with large health care needs, and should make smaller contributions to health plans with a smaller than average number of members with large health care needs. In this fashion, sponsors will reward health plans that do a good job of taking care of sick people, in contrast to the present payment system which punishes them.

Sponsors must help develop and make available to consumers information on the quality of care delivered by health plans. And sponsors must assist providers in developing programs of technology assessment, the risk-adjusted monitoring of outcomes, and outcomes management. Such information is a public good. The profit incentive does not motivate the production of such information in socially optimal amounts. Substantial support by government is both necessary and a wise investment for taxpayers in the long run.

Coverage, Costs, and Budgets

The Congressional Budget Office has estimated the effects of our proposal on coverage, costs, and public-sector budgets.

Of the 35 million people who are currently uninsured, according to CBO estimates, approximately 22 million would be covered by employers under the mandate, and the remaining 13 million would be eligible to purchase coverage from the public sponsors. In addition, 6 million people currently purchasing non-group coverage would be eligible to purchase from the public sponsor.

We estimate that the average cost of a minimum benefit package (similar to the one in the Kennedy/Waxman bill) would be approximately $2400 per family per year. At this premium level, the CBO estimates that our proposal would be budget neutral for the federal government. Revenues raised by the tax cap and by the tax on the wages of part-time workers and the earnings of otherwise uncovered self-employed people would offset new expenditures to support public sponsor activities (see tables for details).

Table 1. Health Insurance Status of the American Population at Present and as Projected under the Proposal.*

Projected Types of Coverage	Totals (Projected)	Current Types of Coverage			
		Employment-based group†	Other private	Medicare, Medicaid, or CHAMPUS‡	None
		millions of people§			
Totals (current)	241.2	135.1	19.7	51.1	35.3
Employment-based group†	178.3	135.1	13.6	7.1	22.5
Medicare, Medicaid, or CHAMPUS‡	44.0	—	—	44.0	—
Public sponsor	18.9	—	6.1	—	12.8

*Source: Preliminary Congressional Budget Office simulations based on the March 1988 Current Population Survey.[29]

†Includes all people with employment-based coverage, regardless of other insurance, except those covered by Medicare.

‡CHAMPUS denotes the Civilian Health and Medical Program of the Uniformed Services. Figures include veterans covered by the Department of Veterans' Affairs.

§People are classified according to their own insurance and work status or that of the family member whose plan covers them.

Table 2. Probable Effects of Full Implementation of the Proposal on the Federal Budget.*

	Cost or Savings (Billions of 1988 Dollars)
Outlays	
Matching contributions to public sponsors	8.7
Subsidies to small businesses	3.9
Subsidies to low-income individuals and families	3.9
Cost added to health-benefit plan for federal employees	0.2
Savings to Medicare, Medicaid, and CHAMPUS†	−3.9
Total	12.8
Revenues	
Payroll tax on part-time workers‡	4.4
Income tax on others eligible to buy from public sponsors	2.5
Cap on exclusion of employer contributions from individual income-tax and payroll-tax bases	11.2
Savings from elimination of all health care benefits from Section 125 of Internal Revenue Code	§
Revenue loss from mandated employer contributions — individual income and payroll taxes	−5.7
Total	12.4
Net effect on federal budget deficit	0.3¶

*Source: Preliminary Congressional Budget Office estimates based on 1988 Current Population Survey and August 1988 base line.[2]

†CHAMPUS denotes the Civilian Health and Medical Program of the Uniformed Services.

‡Net of income-tax and payroll-tax offsets due to lower wages.

§Not yet estimated, but expected to be small.

¶Value shown is approximate because of rounding off.

Effect on Employment and Wages

In a perfectly competitive market, the total payments for each worker's services -- wages, fringe benefits, and payroll taxes -- should equal the value of his or her contribution to the output of the firm. After a period of adjustment, any increase in health insurance costs or payroll taxes would be offset approximately by a decline in real wages. In real labor markets, however, various factors might prevent wages from declining by as much as the employer's increase in costs for health benefits. Thus, increases in health benefits costs might result in higher prices or lower profits.

We expect that our proposal will cause the real money wages of currently uninsured workers to increase by less than they otherwise would over time, although for workers in small firms the magnitude of this change is limited to 8%. In return, these workers and their dependents will be able to obtain medical care when they need it without suffering financial hardship.

Probably the most important negative effect of our proposal, as compared with the status quo, would be a reduction in opportunities for employment among people with few job skills, by, in effect, raising the minimum wage. Further provisions can be designed to attentuate this effect.

Any tax or regulatory mandate distorts economic decision making. If this proposal were enacted, there would be some negative effects on employment, as there are now in our employment-based system of coverage. But the achievement of universal health insurance inevitably entails some taxes and regulations. Our present method of providing health insurance through employment groups is subsidized by taxes to a great degree. We must look for a realistic compromise -- what economists call a 'second best' -- because universal health insurance without some regulation and tax support is impossible. Further, the accelerating cost of health benefits today has negative effects on real wages and employment for the majority of American workers who receive employer provided health benefits. To the extent that our proposal is successful in restraining the rate of cost growth, it would have beneficial effects on wages and employment for many Americans.

Will it Work?

If Congress were to enact a proposal such as ours, would it work? It would certainly get coverage to virtually all of the 35 million Americans who are currently without health insurance. In that sense, it would certainly work.

There is inevitably less certainty about the proposed system's effectiveness in restraining cost growth and in promoting the delivery of high quality and economical care, since forecasting such effects required forecasting the behavior of consumers, sponsors, and providers. The key to success here is creating a structure in which providers (doctors and hospitals) think that it is part of their job (and are rewarded for) providing high quality care in an economical fashion. That is not the case today, in which economical care is rarely rewarded and high quality care is inconsistently rewarded. I think that a financing structure such as the one we have proposed combined with the tools of 'managed competition' will create a system in which high quality, economical care will be rewarded and flourish, but this is not a lead pipe cinch.

I am quite sure that our proposal is far more desirable than the status quo. The status quo is that we have 35 million people uninsured, and an expensive, inflationary health care system in which there is no necessary relationship between increased spending and either better health outcomes or increased desire for spending expressed by 'society'. Surely a system in which all are insured and there is a reasonable chance for promoting economy and quality is preferable to the status quo.

It is also important to remember that the price to get to this new system is comparatively small. We estimate that total health care expenditures would increase by approximately $15 billion (3% of current health care spending and .3% of GNP) in the first year after our proposal was enacted. As Medicare and Medicaid have taught us, the important effects of a new health care program are not seen in the static, first-year effects, but rather in the long-term effects. It is ambitious but reasonable to set it as a goal for our program to restrain the rate of growth in health care spending to a rate of growth close to that of the GNP. If this favorable result were to occur, we would reduce health care costs by $15 billion per year (that is, $15 billion in the first year, $30 billion in second year, $45 billion in the third year, and so forth), as compared with the current path of expenditures. These savings, which would be shared by the government and private employers (and ultimately by wage earners), would soon dwarf the one-time cost increase that our proposal would create.

Comparison to Prominent Alternatives

The proposal from the National Leadership Commission is similar in some respects to our own, but is missing key elements that are needed to promote the delivery of economical, high quality care: namely, the tax cap in particular, and, more generally, the framework needed to make managed competition work.

The proposal from Physicians for a National Health Program differs in two important respects. First, it provides for centralized government financing rather than the current pluralistic, employer based system. There are strong arguments for a centralized financing system, and 'managed competition' with centralized financing was proposed by Alain Enthoven ten years ago in 'A Consumer Choice Health Plan for the 1980s'. But centralized financing would require a tax increase of at least 250 billion dollars. It seems unlikely that we will see this anytime soon, and in the meantime we will continue to have 35 million uninsured and accelerating cost growth.

But if the current health care crisis deepens to the point where centralized financing becomes a political possibility (as it might in a steep recession), then it is important to consider how the money should be allocated. There are many attractions to a system, such as Canada's, in which hospitals receive global budgets and physicians' clinical judgment is not questioned by managers or bureaucrats. Such a system can probably be operated with lower administrative costs than a system based on managed competition.

But the cost of this administrative simplicity is little confidence that doctors and hospitals will see it as an important part of their job to figure out how to provide high-quality, economical care. It is true that the combination of professional norms to improve people's health with resource constraints will push in the direction of figuring out how to use a fixed budget wisely. But we should also expect that provider driven allocations of health care dollars will be strongly influenced by internal politics within the professions and the hospital industry. There is little in such a system to promote the systematic examination of what works and what does not, and to promote the adoption of technologies and treatments that work and to avoid adoption of technologies and treatments that do not.

Chairman STARK. Mr. Ferrara has got a solution for all of this. We will let you wrap it up.

STATEMENT OF PETER J. FERRARA, SENIOR FELLOW, CATO INSTITUTE, ASSOCIATE PROFESSOR OF LAW, GEORGE MASON UNIVERSITY

Mr. FERRARA. Thank you, Mr. Chairman.

My name is Peter Ferrara. I am a senior fellow at the Cato Institute and associate professor of law at George Mason University School of Law. Let me just give you a couple of new ideas real quickly. I know it is the end of the day, and we do not want to go on for too long.

I think it has become more and more clear that mandating employer-provided health insurance has an important cost in jobs. Firms today that do not provide insurance are mostly small businesses or startup firms, and they would be hit hard if they had to bear an expensive mandate. The ultimate result would be that they would cut back in employment, either through contraction or by making other arrangements.

It seems to me the most important employee benefit is a job, and mandating new benefits at the expense of employment is not social progress. But I think there are alternatives which could greatly expand health coverage without adverse employment effects.

For example, why don't we just require employers to report to a State or local agency whether their employees have health coverage? That would be the mandate on the employers. For those who were not adequately insured, the local agency would package them in attractive groups and shop for the best coverage from private insurers. The agency would solicit competitive bids for the groups. And for large enough groups, they might even be able to do something like the Federal Employees Health Benefits system where they offer them a range of option.

Then each worker would have the ultimate choice whether to purchase the insurance that was made available by the agency. But part of the responsibility of the local agency would be to educate the employees about the need for health coverage and repeatedly urge them to obtain it, to lobby them on a regular basis. It seems to me that this is the type of thing that other groups could also participate in. Local churches, community groups, national public interest organizations could all assist in organizing workers into groups and urging them to get coverage.

Now, some employers may find it easier to contribute to employee health insurance under this type of arrangement. If not, the employee would pay for it. In other words, if the employer still was not able to pick it up, the employee would pay for the cost of the insurance. The majority of the uninsured are in families where there are, in fact, full-time workers, and this would be a viable approach for them, particularly if the local agency was sensitive in developing plans that had significant deductibles and coinsurance fees and focused on essential low-cost insurance coverage.

This proposal has no cost to the Federal Government and probably only minimal costs to the State and local governments. At the same time, it focuses directly on what is the key concern, which is

expanding health insurance to the uninsured. The key fallacy in alternative approaches to this goal has been the attempt to also shift the cost of the insurance from the employee to someone else—to employers, to taxpayers or somebody.

The problem with these alternatives is there is no good candidate to shift the costs to. Such cost shifting is always going to have some negative economic effect, and it is generally going to have some unfairness. If you are dealing with people who are in poverty, it is legitimate to ask the taxpayers to pay for their health insurance. But if you are dealing with workers who are not in poverty, it seems to me it is not legitimate, then, to ask some workers to pay for the health insurance coverage of other workers.

Now, another proposal I think would complement this initiative and address the high cost increases that we have seen in health care is the idea of Health Banks. Under Health Banks, you would allow workers with employer insurance to direct the amounts employers now pay for costly first-dollar coverage, which can be 2 to 3 hundred dollars per month and even more, into investment accounts. Some of the funds in the accounts would be used to purchase catastrophic insurance with a high deductible of $1,000 or more per year. The rest of that 2 hundred to 3 hundred dollars a month would be invested and would earn returns tax free, and those funds could be used to pay for health care underneath the substantial deductible.

Now, because you have an attractive vehicle here through which to purchase health insurance, this should encourage more uninsured employees to purchase coverage. At the same time, it gives new incentives to counter rapidly rising health costs and provides workers with more control over their health finances.

It seems to me if the goal is to expand essential coverage, rather than shift expenses to others, then these are a couple of highly promising proposals.

Thank you very much.

[The statement of Mr. Ferrara follows:]

TESTIMONY OF PETER J. FERRARA, SENIOR FELLOW
CATO INSTITUTE
ASSOCIATE PROFESSOR OF LAW
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Many are devoting well intentioned energy to passing legislation which would require all employers to provide health insurance for their employees. But a costly health insurance requirement on all employers would increase the cost of labor, and likely lead to fewer jobs and restricted employment opportunities. Firms that do not provide health coverage are mostly small businesses or start up firms which cannot afford the extra costs. If their labor costs rose because of a costly health insurance requirement, they would have to reduce employment or possibly shut down altogether. Indeed, a stiff health insurance requirement could prevent many firms from ever starting up in the first place. Part time, intermittent, or low skill workers would be the first to lose out. The most important employee benefit is a job. Mandating new benefits at the expense of employment is not social progress.

An alternative approach could greatly expand health coverage without adverse employment effects. Employers could simply be required to report to a state or local agency whether their employees had health coverage. For those employees who were not adequately insured, the agency would package attractive groups of employees and shop for the best coverage from private insurers.

For example, suppose 40 small employers in Chinatown in New York City had 650 uninsured employees. A city agency could market the uninsured employees of those employers as "the Chinatown health insurance group." Or the employers at two or three small tool and die shops elsewhere in the city could be marketed by the agency as another group.

The agency could even solicit competitive bids from potential insurers. For large enough groups, employees could choose from a smorgasbord of possible insurance coverage, just as

under the Federal employee health benefits system.

The agency should primarily seek insurance with relatively high front end deductible and co-insurance fees, leaving the employee responsible for the first several hundred dollars in expenses each year. This would keep the cost of the coverage low, but provide the protection people need for essential, highly expensive, medical care for critical illnesses. The front end deductibles and co-insurance fees would also provide badly needed incentives to economize on more routine medical expenses, helping to counter rapidly rising health costs.

Purchasing the insurance on a group basis would also help to keep costs low. With the state or local marketing agency bearing key administrative and transaction burdens, premiums would be further reduced.

Such administrative assistance from these agencies and the low costs of the insurance structured this way could induce many more employers to finance, or at least contribute, to such insurance. Otherwise, the employees would pay for the group coverage negotiated by the agency. Employee premium payments should be tax deductible, just as those paid by the employers.

The new system would require the consent of each worker, so no one would have to buy insurance they didn't want. But one of the functions of the state and local agencies responsible for the program would be to educate employees about the need for health coverage and repeatedly urge them to obtain it. Local churches and community groups, and even national public interest organizations, could assist in organizing workers into attractive groups and encouraging them to get coverage.

Most of the presently uninsured could be covered this way. Of the 37 million uninsured individuals below 65, just over half

are in families where the head of the household works full-time. Another quarter are in families where the primary earner has worked for most of the year, and may be in transition between jobs. Under the proposed new initiative, the state or local agencies could design the insurance groups to allow workers between jobs to maintain coverage more easily, since the insurance would not be tied to any one employer. The proposal would require no new Federal spending, and minimal new state and local outlays.

This proposal focuses directly on what is professed as the key concern - expanding health coverage to the uninsured. The key fallacy in other approaches to this goal has been the attempt to also shift the cost of the insurance from employees to others - employers, taxpayers, or somebody. The problem with this cost shifting effort is that there is no good candidate to shift the costs to. Such cost shifting would always be both economically counterproductive, destroying jobs and economic growth, and unfair, as some working people should not be taxed to pay the bills of other working people. Those who are working and are not poor must take the responsibility to provide for their own basic needs. Indeed, those who receive employer paid insurance today are not enjoying a free gift. The cost of that insurance is borne by the workers in the form of lower wages than otherwise, as employers set the total compensation, including fringe benefits, equal to the market wage, and increased fringes consequently mean lower take home pay than otherwise. In fact, employees receiving new insurance coverage due to mandated benefits will ultimately find that the cost comes out of their wages as well.

The proposed initiative could be complemented by the idea of Health Banks. This idea would allow workers with employer insurance to direct the amounts employers now pay for costly comprehensive first dollar coverage, currently about $200 to $300

per month and more, into investment accounts. A small portion, perhaps $50 to $75 per month, would be used to purchase catastrophic coverage with high front end deductibles--$1,000 or more per year - and the rest would be invested with the returns tax free. The account funds could then be used to pay for expenses below the deductible. Workers without employer coverage could make the contributions themselves and receive the deduction. This option should encourage more uninsured employees to purchase coverage, and might lead more employers to offer it. At the same time, the higher deductibles and saved Health Bank funds should help to provide strong new incentives to counter rapidly rising health costs, and provide workers more control over their health finances.

If the goal really is to expand essential coverage, rather that to shift a basic living expense of the employed to others, then these proposals are highly promising. If these practical alternatives were pursued with as much energy as currently devoted to impractical legislative mandates, much concrete good would be accomplished relatively quickly, and the problem of the uninsured would in fact be drastically reduced.

Chairman STARK. Thank you.

Mrs. Johnson.

Mrs. JOHNSON. I just want to thank the panel for their ideas and constructive comments and the input into this difficult issue. In view of the hour, I will not pursue additional questions, but I thank you.

Chairman STARK. I just wanted to comment. Mr. Ferrara, I guess I would buy your argument if you would buy mine, I might say. However, you are saying employers having to provide health insurance would shift their costs. You could also say that those who do not now provide health insurance are riding on the coattails of those who do at a competitive advantage. That is a double-edged sword.

One of the things that several of you have toyed with are pooling arrangements—yours is kind of a voluntary pooling; you have suggested, I think, Mr. Kronick, State pools.

I suspect I would like this, unless you all just say you have absolutely no objection: If any of you would have an objection to our offering Medicare benefits at cost, not mandating but just putting it out there as one of the options. I think it is arguably more cost efficient and arguably the marginal costs of expanding it are almost nothing. And, actually, the health insurance companies probably would not mind it because they do not like individual policies much anyway. That is not so popular to the big health underwriters.

It just seems to me that there is—I am not going to even argue about how many ways we could improve Medicare, but I am saying it is there. And as a standard and as one that would be from the benefit side equally applicable in every State and every jurisdiction, it just always occurs to me that this would be the quick answer. Adverse selection would not bother us much because we have got such a huge population in it now. Younger people would argue it would be somewhat less expensive. And it should be no drain on the trust fund if, in fact, we hold to the idea that they pay their way.

As I say, if any of you find that abhorrent for one reason or another, or that it would not work within your idea, I would appreciate hearing from you later why it would not work. I am not suggesting we would make it exclusive or make it mandatory. If Medicare now costs $3,000 a year for seniors, which is about what it costs, it ought to cost somewhere between $1,000 and $2,000 a year for younger, healthier folk, and actually probably save a lot of money in the out-years if you accept the theory that by putting younger, healthy folk into an insured program, by the time they get to be Medicare beneficiaries maybe they would be a little healthier, and it would not cost us so much more then. That is pretty esoteric and pretty hard to prove.

I would like your comments, as I say, on that later because I find that, as we hear from people who approach this perhaps from different academic or philosophic disciplines, we all end up in the same thing; that we have got to pool some of these risks. There are costs that are being shifted; many of the costs are there now. Somebody is paying them. And there really is more continuity to all the

testimony that we have heard this morning than there is disagreement.

It is just a question of who is going to blink first, and how we are going to get about kind of spreading the chairs around a little bit. I appreciate each of you taking the time to participate in this, and I hope that you will continue to keep us challenged, and particularly continue to keep our feet in the fire; because, if not, this problem is going to drag on another 10 or 15 years.

That is my one hope, that we can all work together to develop whatever kind of a solution we are going to find, it has got to be better than what we are doing now. And let us get about it, and recognize we may not get the best, and maybe you will continue to criticize us and be constructive, and we will get a system in place. Then with your help, we will improve it each year.

Thanks a lot for being with us today.

The committee stands adjourned.

[Whereupon, at 12:41 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

The American Dental Association appreciates this opportunity to express its views on the provision of adequate health insurance coverage for the uninsured and underinsured.

The availability of employer-sponsored health benefits, specifically dental benefits, has been a priority interest of the Association since the inception of modern dental prepayment programs in the mid-1950's. Over the last quarter century, we have devoted substantial resources to encouraging employers to provide group dental benefits to workers and their families, and to extend these benefits into retirement and during extended layoffs. This has been done because dental benefits represent the principal proven means of improving opportunities to receive regular, comprehensive dental care.

Today, comprehensive dental benefits are the rule rather than the exception among the nation's larger employers.

In more recent years, the Association's efforts have been directed toward small employment groups. Success here has been limited at best and prospects for future success are not bright. This is principally because of the inadequacies that exist in basic health insurance for many of these workers. Until basic health care expense protection is available to all workers, benefits for other needed health services, including dental care, are unlikely to be realized.

The Association, then, shares the concerns of the Congress about the current inadequacies in health benefits for nearly 50 million Americans, most of whom are working people and their dependents. We differ, however, in the methods that have been advanced and are currently being advanced to correct such inadequacies. In our view, encouragement of employers to provide this critical protection, through positive tax or other incentives, should be thoroughly explored before considering governmental fiat.

To date, such incentives have not been tested. Even basic equity in tax treatment of all employers has yet to be achieved, as evidenced by the legislation now before the Congress to allow full tax-deductibility of health benefits costs to self-employed individuals and owner-operators of unincorporated businesses.

The positive effects of requiring employers to provide basic health benefits are clear. But the negative effects of the cost of these benefits upon some businesses and some workers is also clear.

In our view, projections that mandate on all employers to provide health benefits would, on balance, have no effect on overall employment misses a critical point, namely, that certain categories of employees would be adversely affected.

In labor-intensive industries, currently operating on small margins of profit, adjustments in aggregate labor costs to compensate for the purchase of these benefits would most severely affect people now employed at the minimum wage, whose wage compensation could not be adjusted to pay any part of the new benefit costs. The only alternative, if total labor costs were to be maintained at current levels, would be a reduction of this minimum wage labor force, either through terminations or decisions not to hire into available positions. Such unemploymnent and "disemployment" have been estimated to affect as many as 100,000 persons, mostly young and disproportionately from racial minorities. Undoubtedly, additional health benefits coverage for 24 million workers and their dependents would create new jobs in the health care and health benefits fields. Those would not be positions, however, that the unemployed or "disemployed" would be qualified to fill without extensive retraining.

The possibility of this undesirable effect upon the most vulnerable segment of the working class is sufficient reason to examine positive incentives and voluntary compliance.

Among the incentives that we believe warrant consideration are:

- a bonus business deduction, expressed as a percentage of contribution to premium, for small employers

- a tax credit for employers, expressed as a percentage of premium, to offset their internal administrative costs in sponsoring health benefit programs

- A similar tax credit, but weighted in inverse proportion to employer size (e.g., less than 25 employees, 25% of premium; 25 or more but less than 100, 15%; 100 or more, 5%).

The Association offers any assistance it might provide in examining positive incentives of these kinds.

Additionally, proposals to expand Medicaid eligibility to all persons below the federal poverty level, including those who are employed, and to establish a system of state-based insurance pools to provide coverage for medically uninsurable persons, should be given careful and immediate consideration.

Finally, we want to stress that, while we appreciate the seriousness of the problem of uninsured and inadequately insured workers at all economic levels, the most immediate and pressing benefits coverage problem is the uninsured poor. Accordingly, we urge that proposals to expand Medicaid eligibility to all persons below the federal poverity level, including those who are employed; to establish a standard benefits package for Medicaid nationwide, and to improve claims administration and reimbursement under the program to attract adequate numbers of practitioners, be given immediate consideration.

Thank you for your consideration of our views.

[THIS STATEMENT REPRESENTS THE VIEWS ONLY OF MR. GARBER]

Dissenting Views of Harry D. Garber**
(Vice Chairman of the Board, Equitable Life Insurance Society of the United States)

The Commission set noble goals for itself: to examine the problems of the American health care system and to devise recommendations to solve these problems that would be consistent with our vision of the ideal health care system.

I agree that the three inter-related problems identified by the Commission -- cost, quality and access -- are the key problems afflicting the nation's health care system and that the Commission's explanations of these problems are well drawn. Most of the analytical work done by the Commission's staff and the information sharing among the Commissioners in the many work sessions were extremely useful.

Unfortunately, the Commission's recommendations fall far short of this high standard of performance. Instead of being based on facts, demonstrated experience or scientific evaluation, the recommendations are characterized by partial analysis, wishful thinking and bureaucratic tendencies.

I regretfully dissent from the majority of recommendations in the report and explain my thoughts in these remarks.

Financing Access to the Health Care System

The centerpiece of the Commission's recommendations is the establishment of structure of government financed and operated health insurance pools and private insurance plans that, in combination, should assure access to the health care system for all Americans. The pools would be financed principally by an elaborate system of new taxes imposed on individuals and employers.

The Commissions's objective is a worthy one. The difficulty that the 37 million persons without health insurance now have in accessing the health care system is a personal and national tragedy. The question is not whether it should be remedied -- it must be -- but when and how.

Unfortunately the Commission plan, which purports to be a comprehensive solution, is a hastily assembled structure filled with internal contradictions. We have always known that the problem of financing access to the health care system for those without insurance could be solved any time we were willing to establish a government financed and administered program and to collect sufficient taxes to support it. And in this respect the Commission plan is but another variation on an old theme.

**Mr. Garber was formerly the Commissioner of the National Leadership Commission on Health Care.

The Commission plan, however, does not limit itself to financing access for those who presently lack such access. Instead, the Commission proposes to revamp the entire system of health care financing. There is no question that, contrary to the stated intent of the Commission to develop a plan that "builds on the American tradition of providing private health insurance through the workplace", the proposed plans will produce a significant movement of persons from employer-sponsored plans and other private insurance arrangements to the government pools. This would be the result of the Commission's proposals for a Federally-established set of minimum health care services that plans must provide, a bizarre set of mandates for handling dependent coverage, a specified employer-employee cost sharing arrangement and a rigid tax structure that ignores the immense variations in the cost of health care around the country.

Today, we have almost two-thirds of persons under age 65 covered under employer-provided health insurance arrangments and another 10% covered by other private insurance arrangements. The Commission's consultants estimate that there would be minimal shifting from employer provided coverage. But they have ignored completely the impact that of using a single nationwide employer tax rate, would have on employer decisions as to whether to retain private coverage or shift to pool coverage in areas with relatively high health care costs.

Before we undertake a comprehensive program to solve the access problem, particularly a program relying so heavily on tax financing and government administration, we must have confidence that the cost and quality problems are under control.

Today, the Federal and state governments, between them, administer the Medicare and Medicaid programs covering about 70 million aged, poor and disabled beneficiaries and involving annual expenditures of about $150 billion. These programs suffer from inadequate cost controls, inadequate access to care for the poor, and an inability to measure and purchase quality services for beneficiaries. Employer sponsored plans have not fared much better in cost control. If we as a nation have learned anything from our experiences with Medicaid, Medicare and from the experience of employers who "promised" retiree health benefits to employees, it is that we cannot make and expect to keep promises of future health benefits as long as the health care system remains "out of financial control." Our failure to heed this experience can lead only to disappointed citizens and increasing budgetary strains.

Even if these basic questions were not present, the Commission plan lacks some essential details. For example, the following key questions are unanswered by the report.

Who would set the tax rates and how would they be set? Who would collect the taxes? If the Federal government collects them, how would the money be distributed to the states?

What is the relationship between the tax rates, pool premiums (for employers opting to insure through the pool), and local medical costs, and how will this affect decisions by employers as to whether to offer or to retain a private health plan?

What price discounts will the pool be able obtain from providers? What cost shifting to private payers will result?

How many jobs will be lost as a result of these additional employer costs? Is the assertion in the report that less than 100,000 jobs will be lost reasonable in light of the additional employer tax/benefit plan expenses?

Cost and Quality

The Commission fails to address substantially the question of the rising cost of the nation's health care system. The central recommendation in this respect is that the state agency administering the pool take on the major responsibility for achieving overall health care cost control within the state and that private payers be permitted to benefit from any negotiated price structures.

There are at least two major problems with this proposal, both of which are likely and either of which would render it ineffective. These are:

. The primary task of the state agency must be, in the end, to keep expenses less than or equal to revenue. If the history of Medicaid is any guide, this will result in very low reimbursement rates to those who provide services to the pool beneficiaries, with the resultant cost shifting to private payers. Attempting to represent all payers would present an unresolvable conflict of interest to the state agencies.

. The American system of government involves built-in separations of power among the several branches of government and between Federal and local authorities. It requires, as a consequence, detailed legislation in matters affecting the rights of its citizens. I cannot conceive of a state entity having the legislative authority and expert skills to make the business decisions and judgements required to achieve the necessary cost/quality results. In no other sector of our society have we turned to a governmentally run system as a cure all for problems. Indeed, the history of our government's administration of the current Medicare and Medicaid programs gives no comfort that it would be equal to the challenge presented by the Commission.

With respect to the issue of quality, the Commission recommends a national quality improvement initiative, a major component of which would be sharply increased funding of research on the results of clinical practice. This research would provide a basis for professional standards of practice. There is no question that such research is needed, that substantial additional resources will be required to fund it, and that the professional societies

must be involved in the development and implementation of the necessary professional standards. The substantial question that remains is whether the levying of a $500 million tax is the most effective way to approach the funding of this work, particularly given the current short supply of experienced and interested researchers in this area. I do not believe it is.

Suggestions for Action

Our health care system is unique in the world. I believe that it is possible to preserve its unique qualities while remedying the existing problems of cost, quality and lack of access. But it requires an immense social and economic engineering project involving providers, payers, governments, patients, insurers and other intermediaries, unions, and other interested parties. In the end the providers must be organized to provide quality and cost-effective services, and buyers of their services must possess sufficient market power to assure that this is the case. And all of this must be done locality by locality, because the health care system is composed of hundreds of local markets.

What we need to recognize is that this result can happen only if someone makes it happen and the only "somebodies" that can make it happen today are the employers, working with their insurers. The major employers, who pay most of the bills presently, must recognize that they are the only entities with the resources and incentives to solve the cost/quality problems and that they need to undertake the hard work of doing so. Instead of recommending a government program that purports to solve the cost/quality problem for the employers -- if it works -- the Commission should have taken the more realistic route of challenging the employer community to assume the initiative and a major share of the responsibility for the solution of these cost and quality problems.

Conclusion

The Commission report is worthy of review more for its definition of current problems in the health care system and its vision of the future than for its detailed recommendations. The recommendations will not help us to achieve our vision. The report is, indeed, a missed opportunity to have a positive impact on the health care delivery system.

STATEMENT OF MARTHA McSTEEN
NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am Martha McSteen, and I am the new President of the National Committee to Preserve Social Security and Medicare. Our organization represents over five million members and supporters, nearly all of whom are senior citizens.

But I am not here today to press for more and better Medicare benefits for Seniors. I am here today to urge you to develop a universal health insurance plan that would provide basic, high-quality and affordable care for all Americans.

Why? The National Committee believes that Seniors have as much at stake in a universal system of affordable care as any other group. Perhaps more. I would like to quote here from a policy statement adopted by our Board of Directors last year:

"Medicare cannot be separated from the larger health care industry in the United States. Throughout our health care system, costs are rapidly escalating beyond the management of consumers, insurance companies, the business sector or the government. Since seniors require more health services than younger citizens, they will continue to be most vulnerable to wildly escalating costs until a national reform of our health care industry is undertaken."

This statement is from our publication called "Strengthening the American Family," which is our legislative plan for the 101st Congress.

For Seniors, support of national health insurance and of high-quality, affordable health care for everyone is a matter of enlightened self-interest. From a societal standpoint, there is both a strong economic argument and a moral imperative. Increasingly, our society is coming to view health care as a fundamental right, not a privilege. High-quality, affordable health care is a basic need of all American families.

As an organization primarily of Seniors, we are of course very concerned about the lack of long-term care. We are also concerned about the lack of prenatal care for impoverished young mothers and the shamefully high infant mortality rate that reflects it. We are concerned about the impact of flu epidemics on seniors, and we are also concerned about the resurgence of tuberculosis and the tenacity of measles and malnutrition among infants and young children in poor neighborhoods.

National health insurance is an old concept, and I am pleased that at last its time has come. Over the past year, at least three different plans have been proposed. A national health insurance plan developed by the Harvard-based group called Physicians for a National Health Program was published in *The New England Journal of Medicine* earlier this year. Another set of proposals has been offered by Prof. Alain Enthoven; he calls them the "Consumer Choice Health Plan for the 1990s." These proposals also appeared in *The New England Journal of Medicine.* Finally, there is the approach developed by the National Leadership Commission on Health Care, in which we are especially interested.

In the past, organized medicine has opposed national health insurance proposals as socialized medicine. None of the most talked-about plans, however, can be regarded as socialized medicine. This is because they do not envision either government-owned hospitals and clinics or doctors in the direct employ of government.

We are pleased to see that some doctors are taking the lead in developing creative proposals for universal health insurance, or promoting the general idea, or both. Among these physicians, perhaps the best known is Dr. Arnold Relman, the distinguished editor of *The New England Journal of Medicine*. In a recent editorial, Dr. Relman wrote that in his view, "nothing short of a comprehensive plan, which includes improved technology assessment and malpractice reform as well as other reforms in medical practice, is likely to achieve the goals of universal access, cost containment, and preservation of quality that everyone seems to want."

We like the approach recommended to you by the National Leadership Commission on Health Care. In particular, we support the idea of a built-in program of technology assessment that is well-funded. We support the call for better evaluation of the safety and effectiveness of therapeutic innovations. If there is one thing that virtually all parties to this national debate can agree on, it is that what works and what doesn't work in clinical medicine is less than crystal clear. Yet this is precisely the knowledge that the medical profession must have in order to develop sound practice guidelines and to proceed with confidence in the areas of quality assessment and quality assurance.

The key here, in our view, is adequate funding. Multi-center, randomized controlled clinical trials are expensive and time-consuming. An impatient public does not always wish to wait. But for a tiny fraction of what the nation now pays for medical services of questionable value to patients, we ought to be able to buy well-designed clinical studies that will provide answers about what works, for which patients, and under what conditions. And we think the information should be shared with doctors and beneficiaries alike.

Dr. Relman has argued that his fellow physicians "will have to plan an active and constructive part in shaping a new health care system because no comprehensive arrangement is likely to succeed without their cooperation." We would say the same thing with regard to patients, including Seniors.

Thank you.

NRC National Rehabilitation Caucus

A national focus for the advancement of rehabilitation . . . through advocacy, education, research and communications

April 21, 1989

The Honorable Fourtney Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The undersigned organizations of the National Rehabilitation Caucus (NRC) strongly recommend that potential legislative remedies extending health insurance protections to uninsured Americans include coverage for comprehensive rehabilitation services.

During the 100th Congress, legislation was introduced which would have mandated employer-sponsored minimum health benefits for workers and their dependents. NRC was seriously concerned that that legislation, for the most part, failed to include comprehensive rehabilitation service coverage, particularly for services provided in community-based settings. For this reason, our comments relate primarily to coverage for working individuals. We firmly believe, however, that access to comprehensive rehabilitation services must be an integral part of any solution to problems confronting the nation's uninsured.

We urge you to give careful consideration to our recommendations. Please include our comments in the record for the April 6, 1989 hearing held by the Subcommittee on Health regarding "Health Insurance and the Uninsured."

NRC member organizations represent a broad spectrum of rehabilitation service providers, professionals and related interests. While the NRC recognizes that there is considerable pressure to limit new or mandated benefits, we also believe that access to rehabilitation services in acute, home and community-based settings is critical to a minimum health benefit plan for all Americans.

Rehabilitation services promote the restoration of functional abilities of individuals with physical, communicative, cognitive, and sensori-perceptual impairments. Rehabilitation includes a broad range of services, including physical therapy, speech-language pathology, occupational therapy, audiology, rehabilitation nursing, assistive device technology, homemaker-home health aids, and physician services. Rehabilitation occurs in a variety of settings, such as hospitals (freestanding and distinct rehabilitation units), rehabilitation agencies, skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and private offices and homes. The extent to which medically necessary services are covered often involves limitations on duration and frequency of service, and caps on expenditures.

Quality health care includes a broad spectrum of hospital, home and community-based rehabilitation services. Rehabilitation is tailored to the unique needs of the

patient. Consequently, access to a range of services in a range settings maximizes patients' opportunities to receive timely and appropriate care and maximizes individual function, independence, and ideally, return to work.

Limiting rehabilitation coverage under a minimum benefit plan to hospital settings seriously jeopardizes employee access to high quality service alternatives in the home and community. This strategy fails to consider the trend towards shorter hospital stays, which has shifted a substantial level of intensive rehabilitation care to settings other than hospitals. Furthermore, for workers and their dependents with serious illness, injuries, and disabilities, limits on access to care frequently translate into less than optimum recovery.

Early access to rehabilitation services frequently prevents the development of secondary problems, either physical, mental or behavioral, which can have an enduring and detrimental influence on an employee's recovery process. If rehabilitation is appropriately timed for critical periods in the recovery process, immediate and long-term treatment effects are going to be greater than if the same rehabilitation services are provided under those critical periods.

For these reasons, we believe that individuals covered under an employer-sponsored or other benefit plan deserve the opportunity to receive services in the setting most appropriate to their personal and health needs. At a minimum, therefore, rehabilitation services available in hospitals also should be covered in home and community settings.

In terms of cost-effectiveness, rehabilitation ranks favorably as an alternative to extended acute care. Research shows that the average costs for rehabilitation are two-thirds that of acute care. For example, early rehabilitation saves an average of $6,404, for each surviving stroke patient fortunate enough to receive it. In fact, cost studies of stroke rehabilitation show considerable return on the investment in services. A person who is not rehabilitated costs $92,736 in 1980 dollars more to support than a rehabilitation patient living at home. The average cost of rehabilitating an individual who has had a stroke is $8,000 to $11,000 in 1980 dollars. This results in average savings of $81,250 to $84,740, again in 1980 dollars.

Notably, a recently completed survey by the Health Insurance Association of America concluded that for every dollar spent on rehabilitation, $11.00 is saved in other benefits that would have been paid to the affected individuals.

Other studies have shown similar results:

* A 1981 Insurance Company of North America study concluded that in long-term disability cases, for every dollar spent on rehabilitation, $17.00 is saved in other benefits that would have been paid to the beneficiary.

* In 1981, Natisco Rehabilitation Management, Inc., a case management company, estimated that for every dollar spent on rehabilitation, $12.68 was saved in claim costs.

* Several studies on spinal cord injuries concluded that for every dollar spent on rehabilitation, $3.00 to $6.00 is saved.

In order to take full advantage of rehabilitation's cost-effectiveness, coverage for these services must extend to a variety of settings. The NRC recommends, therefore, that legislation extending health coverage to workers reflect that rehabilitation in hospital, home and community settings is considered an integral part of the minimum employee health benefit.

Coverage for rehabilitation services is widespread. Public and private health insurers customarily include some level of coverage for rehabilitation services in the benefits they offer. Coverage for rehabilitation services is delineated in terms of type of service, site of service delivery, and scope of service, and describes which services are covered, where services are covered, and how services are provided.

A substantial share of employee health plans include coverage for rehabilitation services. For many employers, the impetus for including this coverage is based on the recognition that the relative costs of rehabilitation services are preferrable to the high costs associated with long-term worker disability. In 1985-86, the Institute for Rehabilitation and Disability Management, a joint venture between the Washington Business Group on Health and the National Rehabilitation Hospital, conducted a national survey of 400 major employers. Some of the significant findings include the following:

* Sixty-five percent of the surveyed companies reimburse for rehabilitation services in community hospitals, while sixty-one percent reimburse for rehabilitation services in rehabilitation specialty hospitals.

* Seventy-two percent of the responding companies reimburse for outpatient rehabilitation services.

* Eighty-one percent reimburse for inpatient and outpatient physical therapy.

* Fifty-three percent of the responding companies reimburse for home-based rehabilitation services.

Thus, a minimum benefits package that would exclude rehabilitation services provided in settings other than hospitals would undercut benefits currently provided by most major employers. Rehabilitation services have been added to employer-paid health benefit plans at little or no cost. In Maine, for example, an insurer added speech-language pathology services to a health plan with no increase in cost. Similar coverage by other insurers has resulted in additional premium costs ranging from $0.12 to $0.48 per employee per month.

States have also realized the value of worker access to rehabilitation services. Workers' compensation programs, present in all 50 states and the District of Columbia, routinely provide for some level of rehabilitation care. Rehabilitation service provisions range from minimum assistance, such as in Indiana and South Carolina, to full coverage of the costs of physical rehabilitation, as in the case in Oregon, Ohio, Texas, Kentucky, Massachusetts, Alabama and Alaska. In West Virginia, medical services and devices are authorized for physical rehabilitation. Additionally, provisions for compulsory rehabilitation, often furnished at the employers' expense, are contained in the workers' compensation laws of Connecticut, California, Delaware, Florida, Minnesota, Nebraska, Nevada and New Hampshire.

In addition to the broad coverage extended to rehabilitation services in federal health programs, such as Medicare and Medicaid, there is a precedent for federally-mandated minimum health coverage that includes rehabilitation. Under the Federal Health Maintenance Organization (HMO) Act of 1973, guidelines specifically require that short-term rehabilitation services be available to enrollees. Unfortunately, HMO interpretation of this requirement remains a problem. Additionally, the Group Health Association of America reports that 99% of HMO plans offer physical therapy services, 97% offer home health benefits. 91% offer benefits for communicative disorders that are delivered by speech-language pathologists, and 80% offer occupational therapy benefits.

NRC Recommendations

Based on this evidence and the belief that a meaningful minimum health benefit must include access to a range of rehabilitation services in acute, home and community settings, the NRC urges you to promote legislation which ensures comprehensive rehabilitation service coverage to workers, their dependents and others who are currently uninsured. Such legislation should clearly state that rehabilitation encompasses a range of services, including physical therapy, occupational therapy, speech-language pathology, audiology, rehabilitation nursing, homemaker-home health aide, and assistive devices in home and community-based settings.

Incorporation of coverage for these rehabilitation services in any legislative solution you craft will dramatically improve access to the full spectrum health care potentially required by the uninsured Americans you intend to assist. In the absence of coverage for these services, many individuals will simply forego needed rehabilitation care, thereby jeopardizing their health and risking more serious and costly health problems in the future. Ultimately, passage of a minimum health plan which adequately provides for rehabilitation services beyond the hospital setting is in the best interest of employers and will appropriately address the health needs of American workers, their families and others who comprise the nation's under-insured and uninsured population.

Thank you for your consideration of our recommendations presented here.

Sincerely,

Steven C. White

Steven C. White, Ph.D.
Chairperson, National
Rehabilitation Caucus

On behalf of:

American Academy of Physical Medicine and Rehabilitation
American Congress of Rehabilitation Medicine
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
National Association for Home Care
National Association of Rehabilitation Agencies
National Association of Rehabilitation Facilities
National Easter Seal Society

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